Cleveland Clinic
South Pointe Hospital

Community Health Needs Assessment

2025

Table of Contents

South Pointe Hospital 2025 Community Health Needs Assessment

Introduction

South Pointe Hospital, a 172-bed[1] acute care teaching hospital within the Cleveland Clinic health system, has served Warrensville Heights and surrounding communities for decades, evolving from the 1957 founding of Brentwood Hospital and Suburban Community Hospital. The hospital is known for its leading orthopedic services, subacute care, and outpatient rehabilitation, South Pointe offers a full continuum of care including emergency services, surgery, specialty programs, and both acute and sub-acute care. As a teaching hospital, it remains committed to advancing high-quality, compassionate care while training future generations of physicians.

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

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

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

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

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

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

CHNA Background

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

South Pointe Hospital Community Definition

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

Figure 1: South Pointe Hospital Community Definition

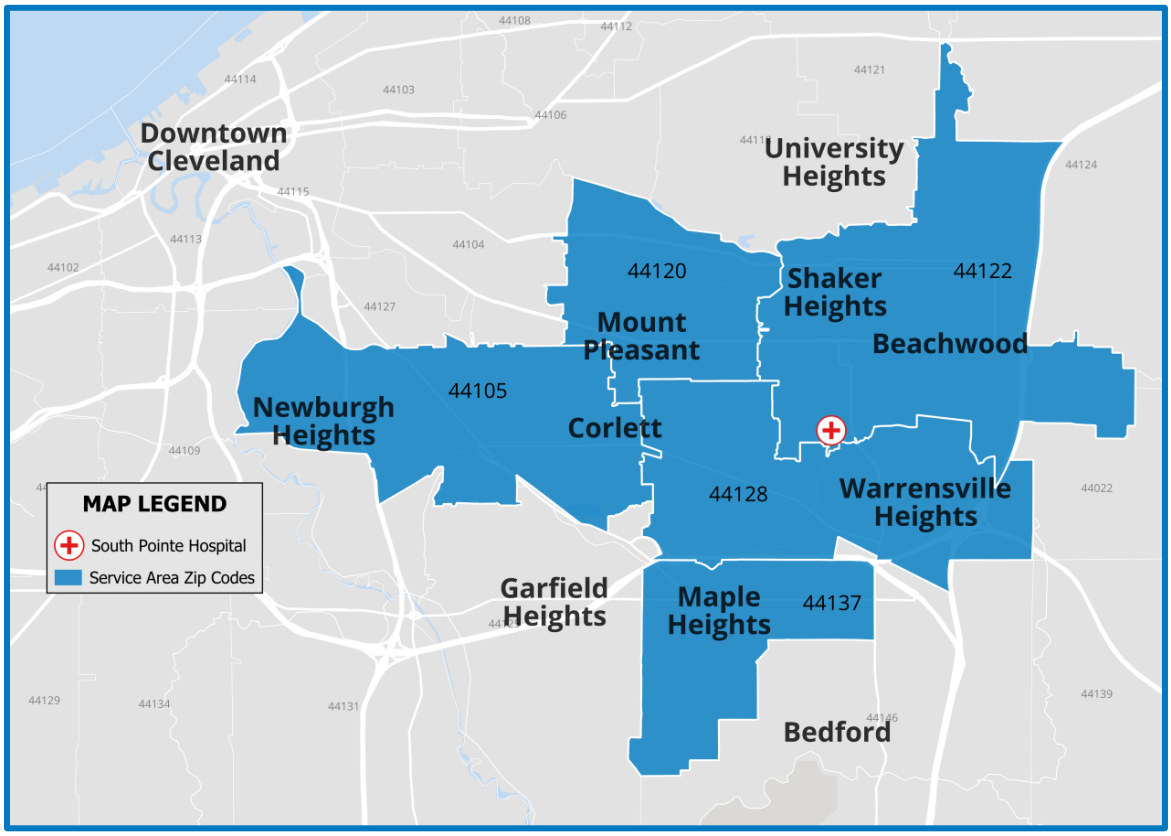


Table 1: South Pointe Hospital Community Definition

Zip Code	Postal Name
44105	Newburgh Heights
44120	Mount Pleasant
44122	Beachwood
44128	Warrensville Heights
44137	Maple Heights

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 5-zip-code South Pointe Hospital community area. 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 nonprofits, hospital systems, and regional health collaboratives, corroborated the relevance of the five prioritized needs prioritized in this 2025 CHNA process for South Pointe Hospital.

Across communities, consistent themes emerged: cost barriers and provider shortages limit healthcare access; behavioral health treatment gaps remain significant; chronic disease management is challenged by food insecurity and inadequate recreational infrastructure; 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.

Primary Data Methodology and Key Findings

To ensure community priorities and lived experience were centered in this assessment, conversations were held with community stakeholders across the South Pointe community. Community stakeholders from a total of 18 organizations provided feedback specifically for the South Pointe Hospital 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 competent prenatal care. Economic hardship was described as a root cause affecting every other health domain. Stakeholders called for expanded prevention, investment in community infrastructure, and system-level changes that address the underlying conditions shaping health across generations.

Summary

2025 Prioritized Health Needs

South Pointe Hospital's 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 the hospital's defined community continues to exceed state and national benchmarks in these areas, underscores the urgency of sustained, cross-sector efforts to improve health outcomes across populations in the community served by South Pointe Hospital.

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

Prioritized Health Need #1: Access to Healthcare

Access to Healthcare remains a critical challenge for the South Pointe Hospital community, as underscored by 2025 CHNA stakeholder feedback. While the area has local healthcare assets, residents. especially those from low-income households, older adults, and communities of color, face persistent and intersecting barriers that delay or prevent care. Affordability was repeatedly cited as a core obstacle, with high out-of-pocket costs, inadequate prescription coverage, and the financial burden of follow-up visits discouraging timely treatment. Transportation limitations, particularly for those in outlying neighborhoods or with mobility challenges, further restrict access. Stakeholders also pointed to shortages of specialty providers, extended wait times, and the need for more integrated service models, such as pairing primary care with behavioral health and social support resources, that reduce fragmentation. Culturally and linguistically appropriate care was another consistent theme, with calls for expanding interpretation services, building trust in the healthcare system, and addressing differences in healthcare experiences between populations. Together, these factors create a complex access landscape that stakeholders believe must be addressed through coordinated, community-based solutions focused on prevention and care continuity.

Secondary indicators indicate that regular preventive care is relatively less common in Cuyahoga County. The rate of adults visiting a dentist is lower than most other Ohio counties, and the rate of adults going to the doctor regularly for checkups is among the lowest Ohio county rates. The county's rate of preventable hospital stays is relatively high, and Black/African American population rate is about 50% higher than the general population (5,651 vs. 3,677 discharges per 100,000 Medicare enrollees). This likely indicates an especially high burden of hospital use as a main source of care at South Pointe Hospital, given the hospital community's majority-Black population.

Geospatial data from Conduent HCI's Community Health Index (CHI) further underscores the magnitude of access challenges. The CHI estimates health risk based on health-related social needs associated with preventable hospitalizations and poor health outcomes. In the South Pointe Hospital community, the zip code with the highest CHI score (96.5) is 44105 (Newburgh Heights). Additional details including charts, maps, and additional findings from primary and secondary data for this health need can be found in the appendices section of this report.

Prioritized Health Need #2: Behavioral Health

In the 2025 CHNA for South Pointe Hospital, Behavioral Health, that encompasses both Mental Health and Substance Use Disorder, emerged as one of the most urgent and complex priorities for the community. Stakeholders described persistent gaps in prevention, treatment, and recovery resources, with services often unable to meet the rising demand. Mental health concerns such as depression, anxiety, trauma, and chronic stress were reported as widespread, frequently compounded by poverty, unstable housing, social isolation, and limited access to consistent care.

The COVID-19 pandemic put strain on an already limited behavioral health infrastructure. Participants noted that certain groups, including youth, older adults, and people with low incomes face particularly high risks due to a combination of stigma, language barriers, and a shortage of culturally responsive providers. Substance Use Disorder, especially related to opioid and fentanyl use, was cited as an escalating crisis, with calls for more accessible evidence-based treatment, harm reduction programs, and services that integrate mental health with recovery care. Stakeholders stressed the need for trauma-informed approaches, school and community-based interventions, early identification, and stronger coordination between healthcare systems, social service providers, and community organizations to address root causes and close existing care gaps.

Secondary data illustrate that since 2021, there has been a significant decline in residents reporting their general health as good or better, and this county rate remains lower than most other U.S. counties. The average number of days that county residents report their mental health as poor has similarly been trending upward since 2019.

Health risks related to substance use are comparatively high in Cuyahoga County. The death rate due to drug poisoning is more than twice the Healthy People 2030 target (45.5 vs. 20.7 deaths per 100,000). Across the county, 42.5% of all driving deaths involve alcohol. Both of these rates are in the highest quartile of all U.S. counties.

Geographic analysis using Conduent HCI's Mental Health Index (MHI), which assesses mental health risk based on local health-related social need indicators, offers a more targeted appraisal of mental health risks for the South Pointe Hospital community. In fact, all five South Pointe Hospital zip codes scored above 90 on the MHI scale, indicating severe challenges throughout the community. A more detailed breakdown of MHI values by census tract can be found in the *Prioritized Health Needs in Context* section below.

Prioritized Health Need #3: Chronic Disease Prevention and Management

Chronic Disease Prevention & Management

Key Themes from Community Input

- High Prevalence and Early Detection
- Challenges with Ongoing Management
- Barriers Tied to Social Determinants
- Widespread Impact and Education Gaps
- Lifestyle and Environmental Contributors
- Differences in Outcomes among Different Groups
- Routine Monitoring and Community-Based Screenings
- Aging in Place and Home Modifications
- Dementia and Mental Health as Chronic Conditions
- Reluctance to Seek Care
- Role of Social Support and Isolation among 65+ Community

Warning Indicators

- Age-Adjusted Death Rate due to Kidney Disease
- Chronic Kidney Disease: Medicare Population
- Adults 20+ with Diabetes
- Prostate Cancer Incidence Rate
- Age-Adjusted Death Rate due to Prostate Cancer
- Cancer: Medicare Population
- Breast Cancer Incidence Rate
- Age-Adjusted Death Rate due to Breast Cancer
- All Cancer Incidence Rate
- Stroke: Medicare Population
- Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)
- People 65+ Living Alone
- People 65+ Living Below Poverty Level
- Osteoporosis: Medicare Population

Chronic Disease Prevention and Management remains a major health concern for the South Pointe Hospital community, driven by the high prevalence of conditions such as diabetes, hypertension, cardiovascular disease, cancer, and kidney disease, which affect certain communities more than others. Stakeholders emphasized that many of these conditions could be prevented or better controlled through early detection, consistent follow-up, and access to supportive services, yet residents frequently encounter financial, transportation, and care coordination challenges that delay or prevent effective management.

Health-related social factors such as limited access to healthy food, safe environments for physical activity, and stable housing were described as key contributors to the burden of chronic disease, often exacerbating health differences for low-income households, older adults, and communities of color. Participants also stressed the importance of culturally responsive care, patient education, and integrated service models that connect clinical treatment with nutrition support, fitness opportunities, and behavioral health resources. Expanding community-based prevention programs, improving care continuity, and addressing environmental and lifestyle barriers were identified as essential

strategies to reduce chronic disease rates, improve quality of life, and lessen strain on healthcare resources.

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

Nutrition, Healthy Eating, and Wellness
Stakeholders emphasized that healthy eating, active living, and wellness promotion are foundational to preventing and managing chronic disease. Across the South Pointe community, residents, particularly those in lower-income neighborhoods, face persistent challenges in accessing fresh, affordable, and nutritious food. Many neighborhoods lack full-service grocery stores and rely heavily on convenience stores and fast-food outlets, limiting healthy options and contributing to poor dietary patterns that increase risks for obesity, diabetes, and hypertension. Limited access to safe, appealing spaces for physical activity further compounds these risks. Participants underscored the need for initiatives such as expanding community gardens, mobile and neighborhood-based farmers markets, and culturally relevant nutrition education that reflects local food preferences. They also stressed integrating wellness support into schools, workplaces, and community centers, alongside policy and infrastructure changes that make healthy choices easier and more affordable. These approaches, when paired with consistent outreach and sustainable funding, were seen as essential to long term improvements in community health outcomes.

Consumer data demonstrate that in Cuyahoga County, adults are more likely to rely on fast food, and less likely to cook meals at home, than nearly all other U.S. counties. Conduent HCI's Food Insecurity Index (FII) further illustrates food access concerns in the South Pointe Hospital community, specifically. The two zip codes in this community with the highest FII scores, indicating the greatest food access challenges are 44105 (Newburgh Heights) and 44128 (Warrensville Heights) with scores of 97.7 and 97.2, respectively.

Cancer
While cancer was not among the most frequently discussed topics in stakeholder interviews for the South Pointe community, it remains a notable community concern, particularly with regard to prevention and equal access to care. Participants emphasized the importance of increasing regular screenings and early detection, noting that such measures can dramatically improve outcomes. Health fairs, mobile screening units, and outreach in non-traditional settings were identified as effective ways to engage residents who may have limited interaction with the healthcare system. However, cost, lack of insurance, transportation challenges, and limited awareness of available resources were cited as persistent barriers leading to delayed or missed screenings. Stakeholders also expressed concern about differences in cancer outcomes across groups, pointing to a need for culturally tailored education, targeted outreach in high-risk neighborhoods, and integrated navigation services to connect individuals with timely diagnostic and treatment options.

Cases of prostate cancer in Cuyahoga County are nearly 25% more common than the overall U.S. rate.; the county rate for Black/African males is higher than for the county's

overall male population (175.7 vs. 139.3 per 100,000 males). Black/African American males are also about 65% more likely to die from prostate cancer (39.0 vs. 23.2 per 100,000).

Rates of new breast cancer cases and deaths due to breast cancer in Cuyahoga County are both higher than most other U.S. counties, with the rate of new cases rising significantly. Compared to the overall county female population, Black/African American females experience a similar rate of new breast cancer cases but a higher rate of death due to breast cancer (28.5 vs. 21.9 per 100,000 females), suggesting potential differences in access to timely diagnosis, treatment, or follow-up care.

Diabetes, Heart Disease, Stroke, and Other Chronic Conditions

Stakeholders consistently identified diabetes, high blood pressure, heart disease, and related chronic conditions as widespread health concerns within the South Pointe Hospital community. While many of these illnesses are largely preventable, they are often detected late and remain inadequately managed due to a combination of factors, including insufficient access to affordable primary and specialty care, gaps in health literacy, transportation barriers, and the ongoing financial burden of medications and supplies. Several participants noted that residents frequently learn of these conditions only through screenings, such as those offered at community events, health fairs, or temporary clinics, rather than through continuous engagement with a trusted healthcare provider. This reactive approach, combined with inconsistent follow-up, limits effective long-term management. Stakeholders emphasized the need to expand culturally relevant chronic disease self-management programs, improve patient navigation services, and increase education and ongoing support to empower individuals in making sustainable lifestyle changes and maintaining consistent care over time.

Secondary data indicate that about a quarter of Medicare recipients in Cuyahoga County have diabetes, and a fifth have chronic kidney disease. The county's Black/African American Medicare population are about 50% more likely to have either diabetes (35% vs. 23%) or chronic kidney disease (30% vs. 20%). Stroke mortality in Cuyahoga County is 40.8 per 100,000, lower than the state average but well above the Healthy People 2030 goal (33.4) and rising. Among Medicare recipients, Black residents are more likely to experience heart failure (16% vs. 12% overall) and are also more likely to have hypertension (74% vs. 66%).

Older Adult Health

Older adults remain a priority population for chronic disease prevention and management in the South Pointe Hospital community. Stakeholders expressed heightened concern about social isolation, cognitive decline, functional limitations, and the challenges of managing multiple chronic conditions among seniors. Limited and unreliable transportation, the high cost of medical care, and a shortage of caregiver support were frequently cited as barriers that prevent older adults from attending routine appointments, accessing preventive services, and maintaining consistent treatment.

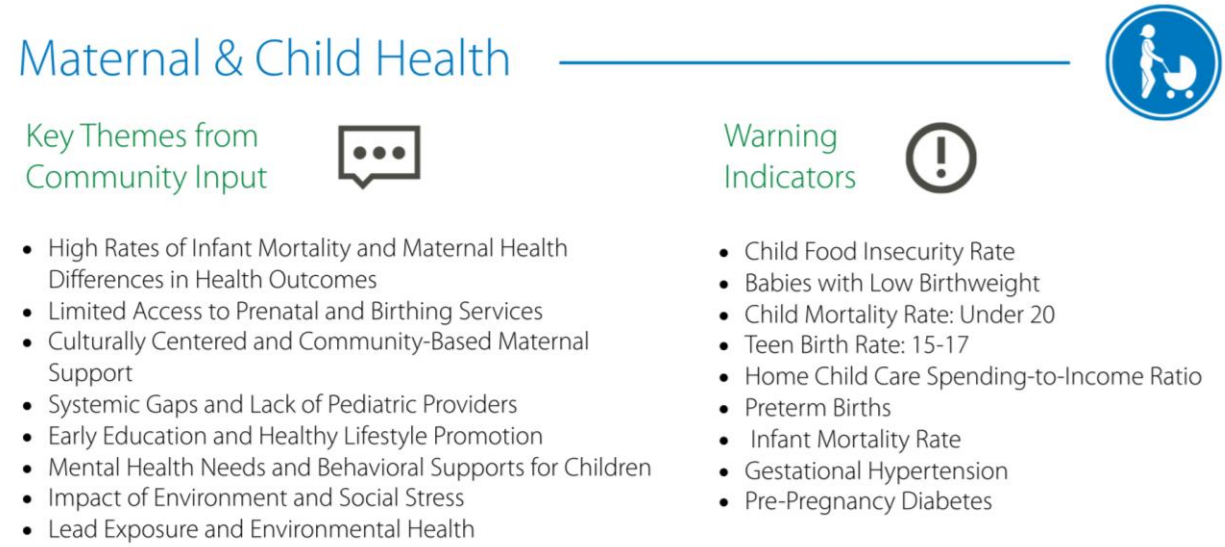
Many participants emphasized the importance of programs that enable aging in place, expanded access to primary and preventive care, and integrated mental health and wellness supports. Strengthening community-based resources tailored to older adults, such as home health programs, senior centers, and outreach services, was viewed as

essential for improving quality of life, reducing preventable hospitalizations, and supporting independence for as long as possible.

Based on scoring of secondary data indicators, Older Adult Health is ranked as the fourth most concerning health need in Cuyahoga County. Over one-third of Cuyahoga adults aged 65+ live alone (36.1%), and 12.3% live below the federal poverty level—both figures exceeding national rates. These factors, combined with transportation and care coordination barriers, place older adults at elevated risk for unmanaged chronic illness.

The high cost for adult day care may help to exacerbate older adult health issues. On average, adult day care costs 13.4% of a typical county resident's household income. This cost is higher for Black/African American households (18.6% of income) and Hispanic/Latino households (24.3% of income).

Prioritized Health Need #4: Maternal and Child Health



In the South Pointe Hospital 2025 Community Health Needs Assessment, Maternal and Child Health remained a pressing priority, with stakeholder insights reinforcing persistent differences in outcomes and urgent service gaps across the community served by the hospital. Interview participants highlighted that maternal and child outcomes spanning prenatal health, birth outcomes, early childhood development, and family well-being are deeply shaped by social, environmental, and healthcare system factors. Concerns were most pronounced for women who face compounded challenges such as limited access to comprehensive prenatal and postpartum care, transportation barriers, unstable housing, and inconsistent insurance coverage.

Perinatal mental health also emerged as a significant area of need, with calls for integrating behavioral health screening and support into obstetric, primary care, and home visiting programs. Stakeholders emphasized the value of culturally responsive and wraparound supports, such as doulas, peer networks, and community-based education, to improve maternal experiences and outcomes.

Children's health was equally emphasized, with concerns centering on preventive care, nutrition, early developmental screening, and the growing mental and behavioral health needs of youth. Participants described long wait times, provider shortages, and limited-service availability as ongoing obstacles to accessing pediatric mental health care. Many called for stronger collaborations between healthcare providers, schools, and community organizations to ensure children have safe, nurturing environments and access to the supports they need to thrive. Addressing these maternal and child health needs holistically was viewed as essential to improving long-term community health, educational attainment, and economic stability.

Based on secondary data from Cuyahoga County, one of the most significant challenges in related to Maternal and Child Health in Cuyahoga County is the overall mortality rate for children. Cuyahoga's child mortality rate (70.8 per 100,000) is in the highest quartile of all Ohio counties. This rate is nearly double for the county's Black/African American children (129.1 per 100,000). Compared to the overall state of Ohio, Cuyahoga County also has high rates of youth not in school or working (2.7% vs. 1.7%) and violent crime (705.9 vs. 331.0 per 100,000)—two factors which may help to exacerbate the risk of mortality among young people. Additionally, relatively high rates of lead exposure add to pediatric health concerns in Cuyahoga County, despite improvements in recent years.

Several maternal and fetal health risks are higher in Cuyahoga County than most other counties across the state, including teen births (7.3 births per 1,000 females), preterm births (12.0%), and low birthweight (10.8%). The risk of preterm birth is higher for the county's Black/African American population (14.8%). Compared to Ohio overall, the rates of gestational hypertension and pre-pregnancy diabetes are also more common in Cuyahoga County and rising, posing health risks for both the infant and birthing parent.

Prioritized Health Need #5: Health-Related Social Needs

In the South Pointe Hospital 2025 CHNA, Health-Related Social Needs emerged as a foundational health priority due to the pervasive influence that these needs have on every other area of concern, including behavioral health, chronic disease, maternal and child health, and access to care. Interview findings revealed that community health is profoundly shaped by factors such as income, employment stability, housing affordability, educational opportunity, and neighborhood safety, conditions that determine a person's ability to access services, adopt healthy behaviors, and manage stress.

Stakeholders described entrenched economic differences, a shortage of affordable housing, and persistent transportation barriers, particularly for older adults, low-income families, and communities of color. Limited public transit options and unsafe or blighted neighborhoods were linked to restricted access to jobs, healthcare, and social supports, while environmental conditions such as inadequate recreational spaces further impacted physical and mental well-being. Education was highlighted as both a protective factor and a pathway to opportunity, yet gaps in quality and resources exist. Participants emphasized that meaningful progress requires cross-sector partnerships, targeted investment in social infrastructure, and community-led strategies that address upstream factors, dismantle systemic barriers, and build resilient neighborhoods for all residents in the South Pointe Hospital community.

Based on the scoring of secondary data indicators, the Economy ranked as the second most concerning of all health and quality of life topics (score: 1.90). Consumer data demonstrate a high financial burden for many basic needs in Cuyahoga County, including

housing rent (19.3% of household income), health insurance (7.1%), and adult day care (13.4%), outpacing both state and national averages. These burdens are especially high for residents of the South Pointe Hospital community, where the rate of poverty is higher than the overall county (17.6% vs. 12.2%).

The topic of Education (score: 1.72) also ranks high among topics of concern, although many of the most concerning indicators here are also related to financial burdens. Cuyahoga County has a higher cost 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.

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

Secondary Data Overview

Demographics and Health-Related Social Needs

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

Geography and Data Sources

Data are presented at various geographic levels (county, zip code and/or census tract) depending on data availability. When available, comparisons to county, state, and/or national values are provided. It should be noted that county level data may mask issues

[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

at the zip code level in many communities. While indicators may be strong when examined at a higher level, zip code level analysis can reveal differences in health outcomes.

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

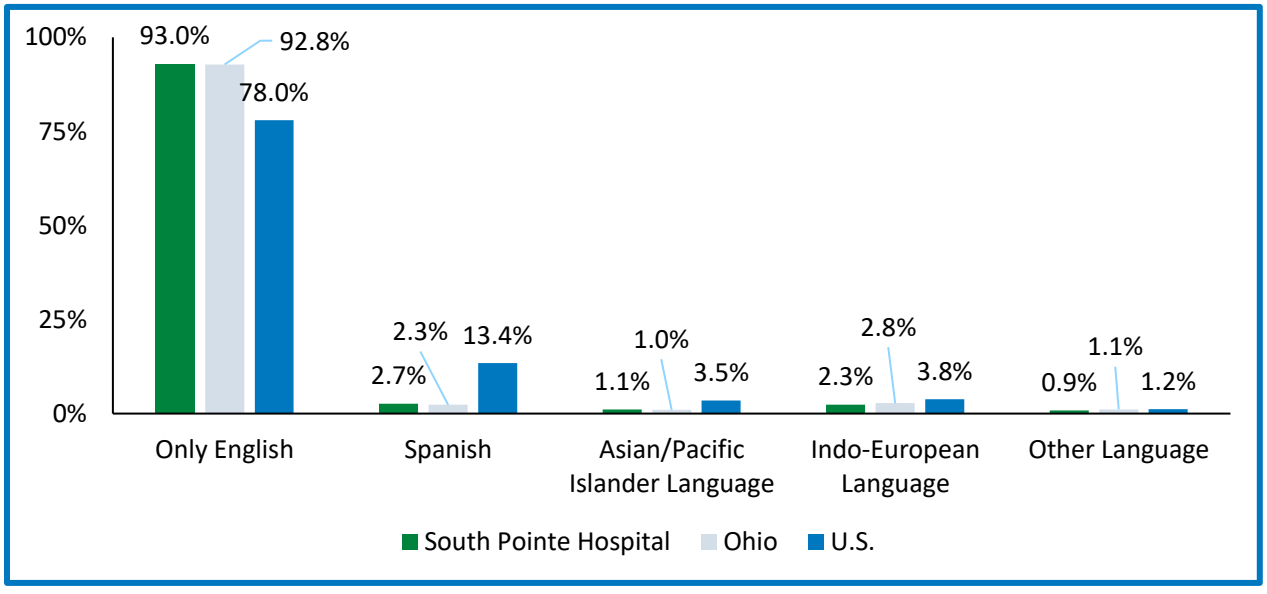
Population Demographics of the South Pointe Hospital Community

According to the 2024 Claritas Pop-Facts® population estimates, the South Pointe Hospital community has an estimated population of 151,970 persons. The median age in the community is 41.6 years, which is older than that of Ohio (40.3 years) and similar to Cuyahoga County overall (41.4). About a quarter of the population (24.9%) is between 25-44 years old.

Black and African American residents make up the majority of the population, at 64.9%. White residents make up 25.8% of the population, and Hispanic and Latino residents make up 3.5% of the South Pointe Hospital community.

As shown in Figure 2, the majority of the South Pointe Hospital community aged five and above speaks primarily English at home (93.0%). About one in forty residents (2.7%) speak Spanish and 2.3% 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

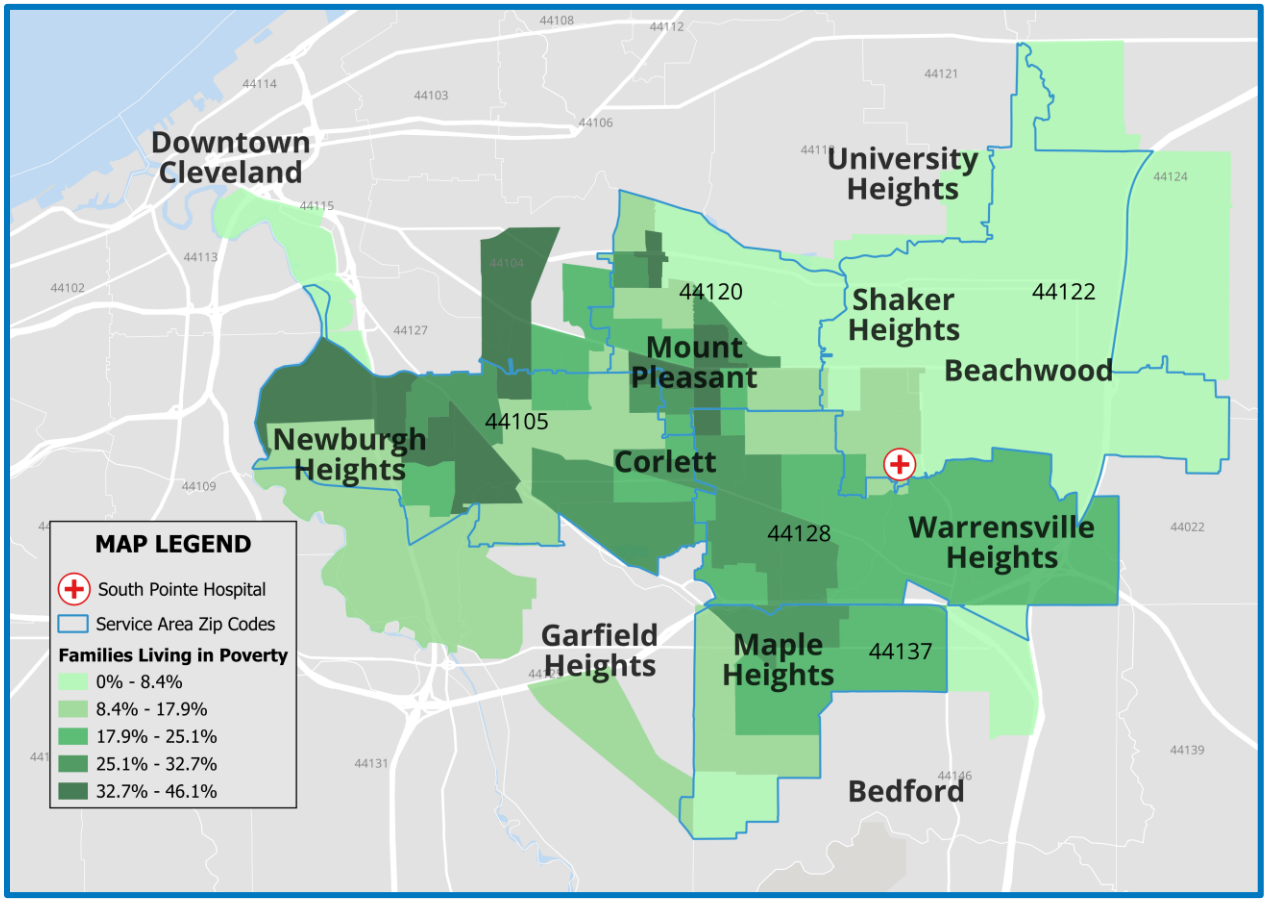
Income and Poverty

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.

The median household income for the South Pointe Hospital Community is $53,765 which is lower than the surrounding county of Cuyahoga and the state of Ohio overall ($63,671 and $68,488, respectively).

Federal poverty thresholds are set every year by the Census Bureau and vary by size of family and ages of family members. In the South Pointe Hospital Community, 17.6% of families live below the poverty level. This is nearly twice the state value (9.4%) and also higher than that of the surrounding Cuyahoga County (12.2%). Poverty levels also differ geographically across the South Pointe Hospital community (Figure 3), and the highest concentrations are in zip code 44105, where more than quarter of the families live below the poverty level (26.1%).

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



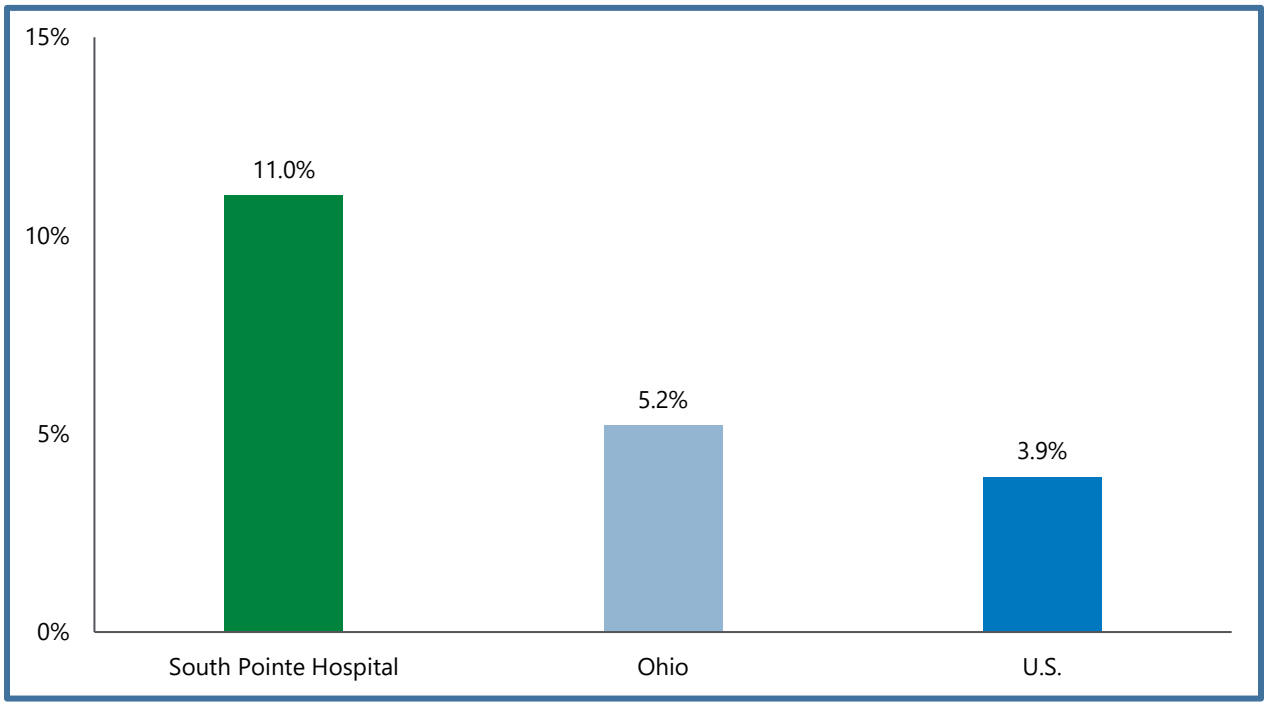
Claritas Pop-Facts® (2024 population estimates)

Education and Employment

The majority of the population within the South Pointe Hospital community have a high school degree or higher (90.1%) and 30.6% have a bachelor's degree or higher, similar to the overall Ohio population (91.4% and 30.2%, respectively). South Pointe Hospital community residents are more likely to have a postgraduate degree (master's, doctorate, or professional degree) than the overall Ohio population (15.7% vs. 11.6%).

Despite relatively high levels of educational attainment, the unemployment rate in the South Pointe Hospital community is 11.0%—more than double Ohio's rate of 5.2%, and nearly three times the national unemployment rate (3.9%).

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



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

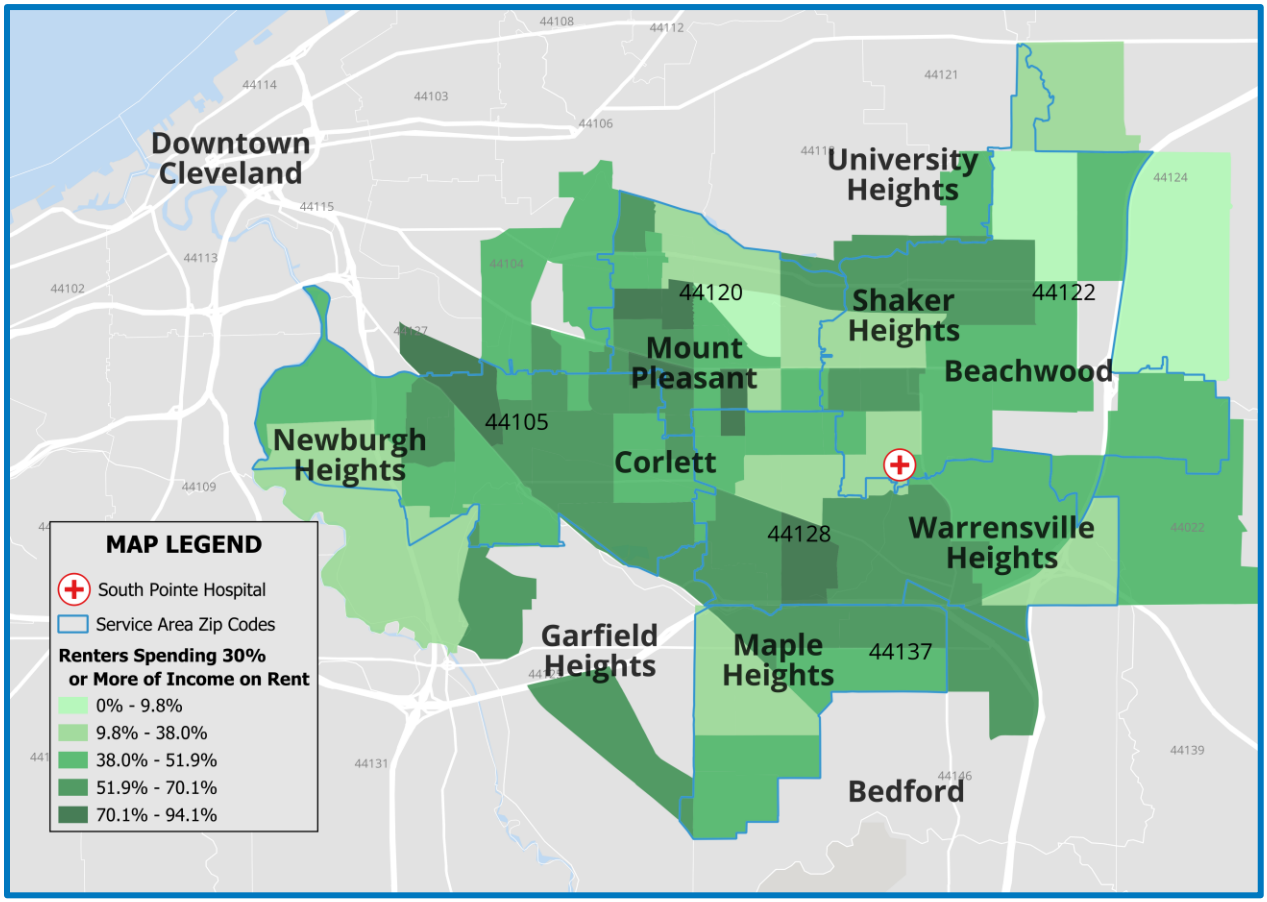
U.S. value: American Community Survey five-year (2019-2023) estimates

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. 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.

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, South Pointe Hospital Community



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

Home internet access is an essential home utility for accessing healthcare services, including making appointments with providers, getting test results, and accessing medical records. The 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 South Pointe Hospital community are in the zip codes 44105 (78.8% of households) and 44120 (78.9%).

Community Health Indices

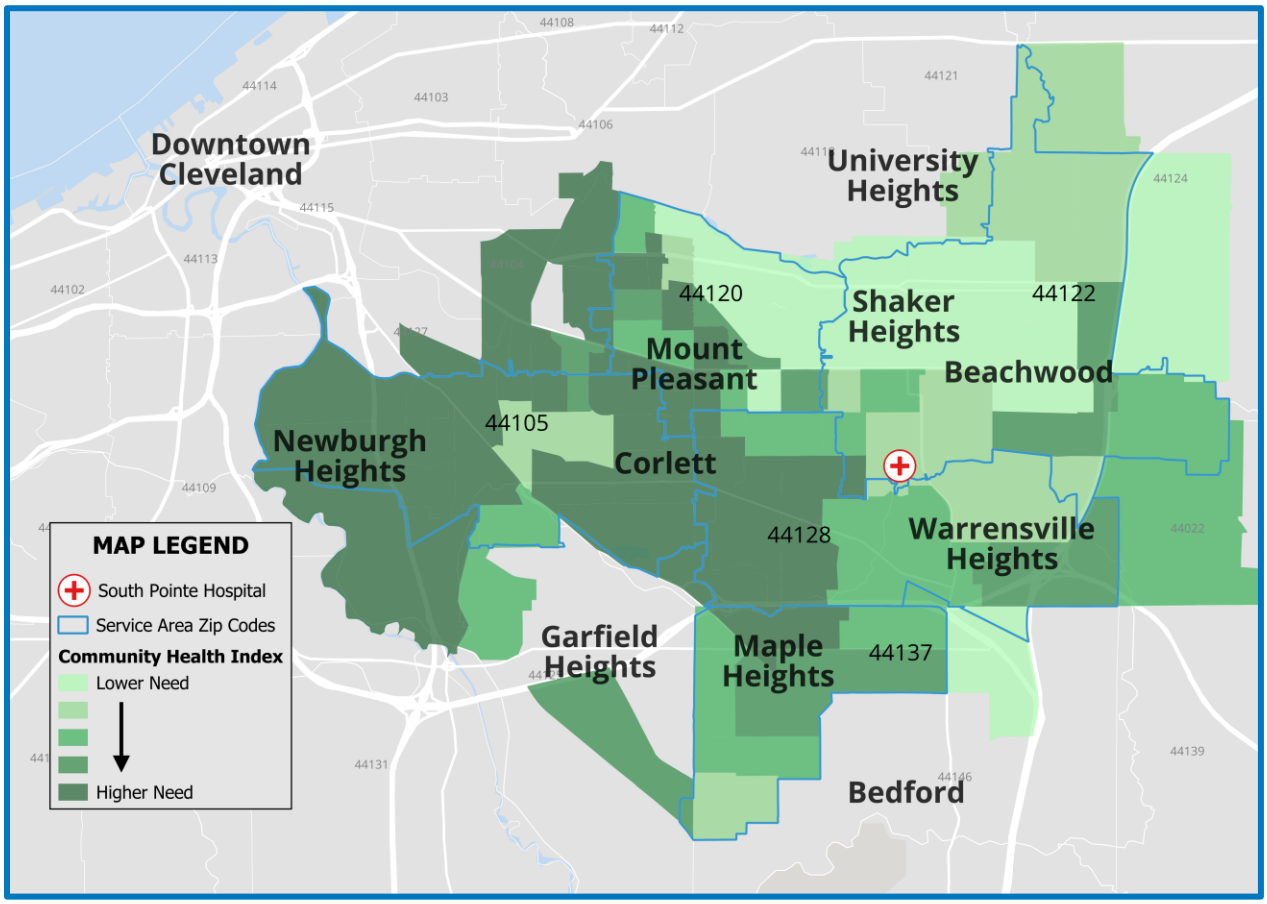
A map index that visualizes social and economic drivers of health at a specific geographic level serves as a critical decision-making tool by highlighting localized differences in health outcomes that may be obscured in broader geographic analyses. The three indices below highlight differences in community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

Community Health Index

Conduent HCI's Community Health Index (CHI) can help to identify geographic differences in health outcomes across the county, down to the census tract level. The CHI uses health-related social 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 South Pointe Hospital community, as indicated by the darkest shade of green. At the zip code level, 44105 has the highest index value of the South Pointe Hospital Community (96.5). See Appendix B for additional details about the CHI and a table of CHI values for each zip code in the South Pointe Hospital community.

Figure 6: Community Health Index by Census Tract, South Pointe Hospital Community

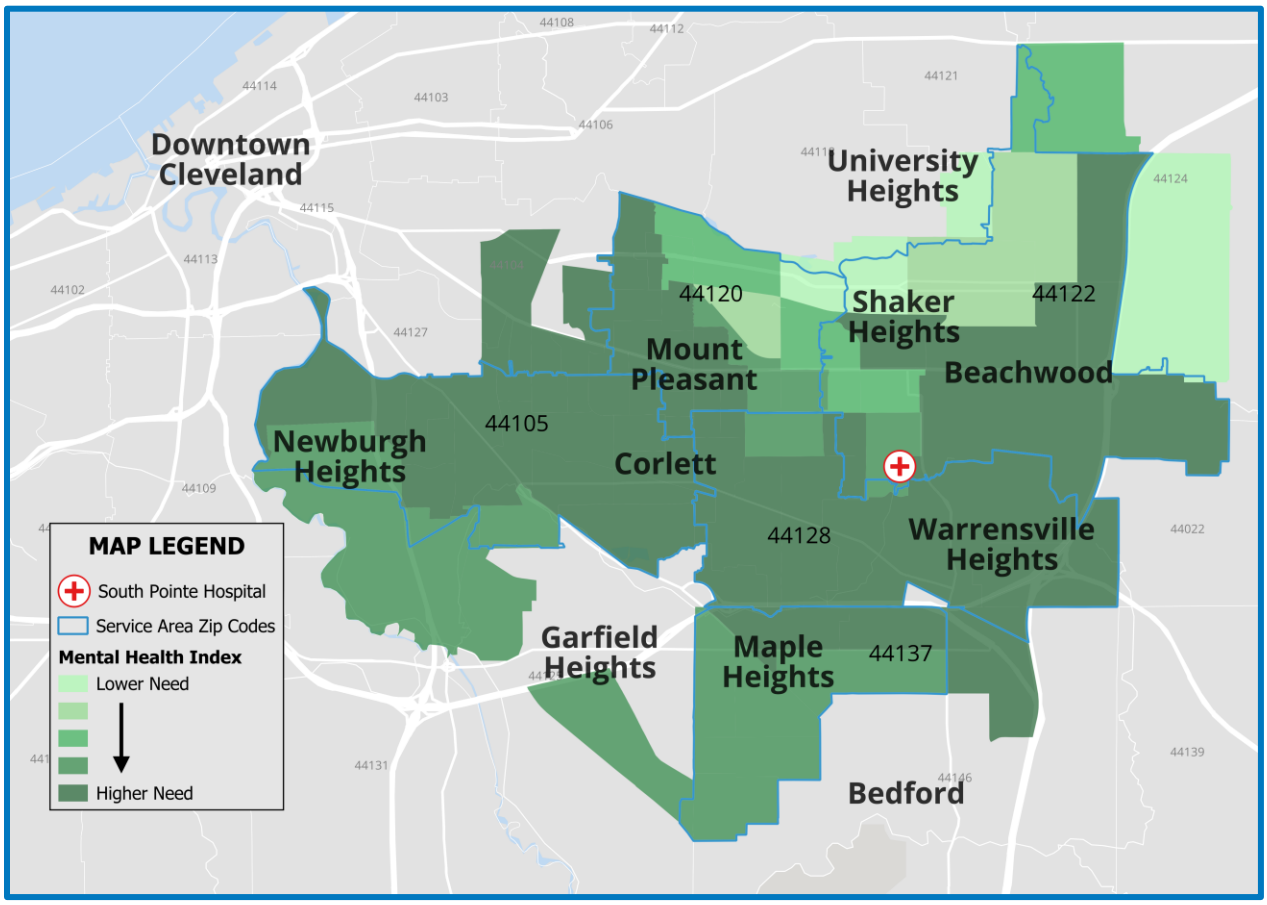


Mental Health Index

Conduent HCI's Mental Health Index (MHI) can help to identify geographic differences in mental health outcomes across the county, down to the census tract level. The MHI uses health-related social 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 South Pointe Hospital Community, as indicated by the darkest shade of green. Notably, all five zip codes in the South Pointe Hospital Community have an MHI value above 90, suggesting especially high mental health needs throughout the region, compared to other U.S. zip codes. See Appendix B for additional details about the MHI and a table of MHI values for each zip code in the South Pointe Hospital community.

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

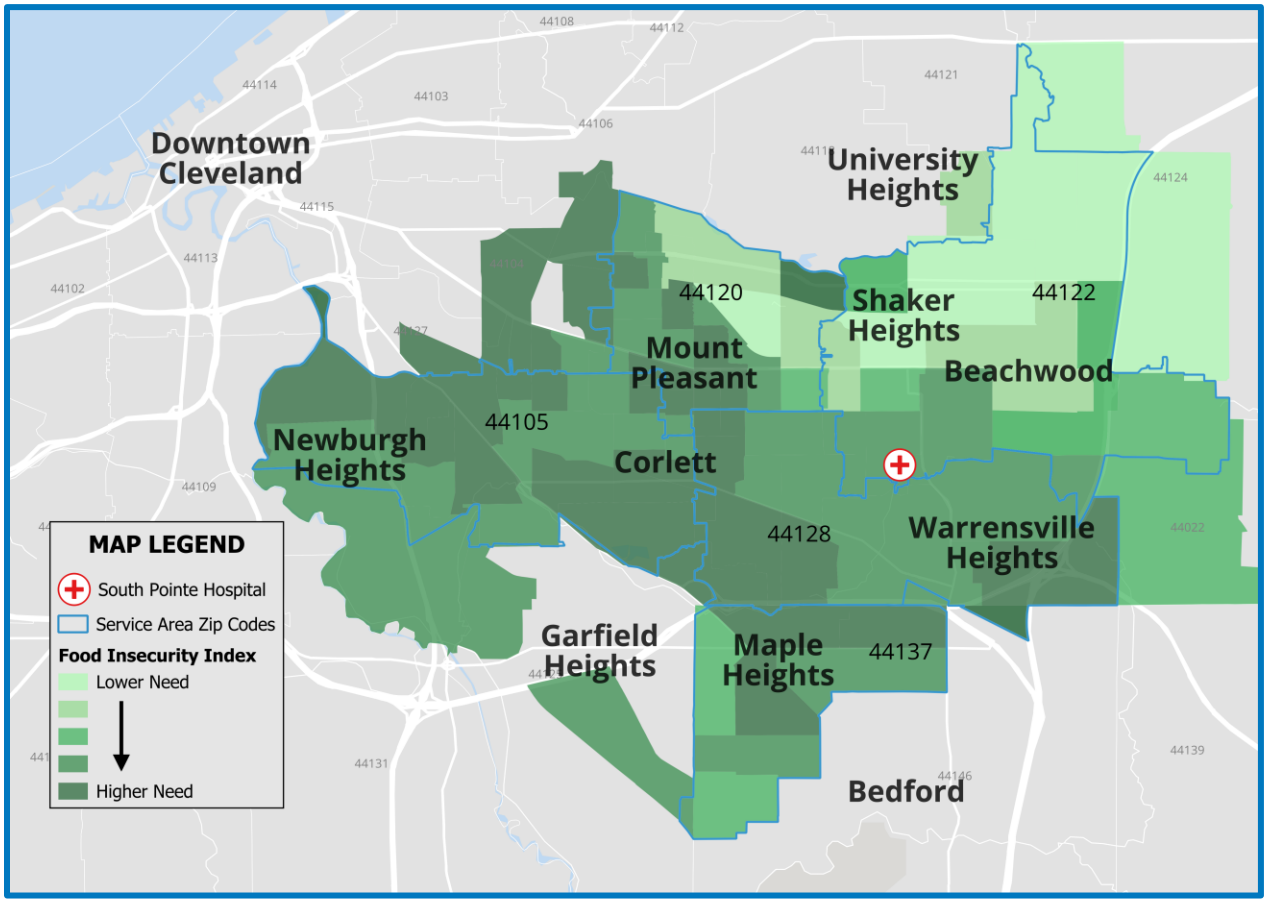


Food Insecurity Index

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

Figure 8 illustrates which census tracts experience the greatest relative need related to food insecurity in the South Pointe Hospital Community, as indicated by the darkest shade of green. Notably, four out of five zip codes in the South Pointe Hospital Community have an FII value above 85, suggesting especially high food access needs throughout the region, compared to other U.S. zip codes. See Appendix B for additional details about the FII and a table of FII values for each zip code in the South Pointe Hospital community.

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



Other Community Assessment and Improvement Plans

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

2023 Ohio State Health Assessment[4]

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

- Access to Healthcare:
    - There are widespread healthcare provider shortages, especially in primary care and mental health.
    - Many Ohioans face barriers such as limited insurance coverage, low health literacy, and lack of cultural and linguistically appropriate care.
- Behavioral Health:
    - Increased rates of depression, anxiety, and suicide among both youth and adults.
    - Significant unmet mental health needs and high levels of substance use, including youth drug use and adult overdose deaths.
- Chronic Disease Prevention and Management:
    - Statewide increases in diabetes and continued high rates of heart disease and hypertension.
    - Obesity and poor nutrition are identified as key contributors to chronic conditions.
- Maternal and Child Health:
    - Stagnant or worsening maternal morbidity and infant mortality rates.
    - Persistent differences in birth outcomes.
- 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.

[4] 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[5]

- 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[6]

- Significant gap between those with substance use disorders and those receiving treatment in Cuyahoga County
- Large disparity 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[7]

- 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

---

[5] 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

[6] 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

[7] 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?

2022 Greater Cleveland LGBTQ+ Community Needs Assessment[8]

- Promote a culture of respect, empathy, and mutual support within and beyond the LGBTQ+ community
- 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)[9]

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[10]

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

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

---

[8] 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

[9] 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

[10] 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

- 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
- 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 & Social Inclusion

- 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
- Race and income impact voting accessibility

2023 United Way of Greater Cleveland Community Needs Assessment[11]

Economic Mobility

- Most children are unprepared for kindergarten; enrollment in preschool
- Childcare access hindered by staffing shortages
- Cleveland ranks as the 2nd poorest large U.S. city
- Significant income differences by race

Health Pathways

- Differences in life expectancy
- High 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

[11] 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

Community stakeholders from a total of 18 organizations provided feedback for the South Pointe Hospital 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 South Pointe Hospital community:

- ADAMHS Board of Cuyahoga County
- ASIA (Asian Services In Action)
- Benjamin Rose Institute on Aging
- Boys and Girls Clubs of Northeast Ohio
- City of Cleveland Department of Public Health
- City of Cleveland, Division of Fire
- City of Warrensville Heights
- Cleveland Clinic Children's
- Cuyahoga Community College-East
- 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
- Mt. Zion of Oakwood
- NAMI Greater Cleveland

In community stakeholder discussions for the South Pointe Hospital 2025 CHNA, Behavioral Health continued to emerge as a top priority, encompassing both mental health and substance use concerns. Participants described persistent gaps in the availability, affordability, and accessibility of services, issues viewed as especially acute for youth, older adults, and low-income residents. The shortage of qualified behavioral health providers, long wait times, and limited crisis intervention options were frequently cited as urgent barriers. Several stakeholders noted that stigma, lack of culturally responsive care, and inadequate language access further deter individuals from seeking help. Youth mental health challenges, including depression, anxiety, and trauma, were highlighted as areas of growing concern, often tied to social isolation, family stressors, and the lingering effects of the COVID-19 pandemic.

Access to Care was a broader recurring theme, with geographic isolation, transportation limitations, service shortages, and financial barriers identified as critical obstacles. Stakeholders pointed to the need for flexible care models, such as mobile clinics, integrated behavioral health in primary care, and expanded telehealth, to reach residents

where they are. Chronic health conditions, particularly diabetes, hypertension, obesity, and respiratory illnesses, were frequently discussed and linked to poor nutrition, physical inactivity, stress, and environmental triggers.

Discussions also reinforced the profound impact of social and economic conditions on community health. Poverty, unemployment, housing instability, and food insecurity were described as overlapping challenges that undermine residents' ability to prevent or manage illness. Education and workforce development were identified as critical long-term levers for improving health outcomes. Several participants emphasized that systemic barriers, such as disinvestment in certain neighborhoods, underfunded public services, and structural racism, continue to drive differences in health outcomes. In addition, mistrust in healthcare institutions, lack of preventive care infrastructure, and fragmented service delivery were cited as ongoing concerns. Stakeholders called for a coordinated, cross-sector approach that addresses both clinical care and the upstream determinants of health, ensuring that solutions are community-driven, culturally tailored, and sustainable over time.

The following quotes highlight key themes highlighted in community feedback:

Priority Area	Key Quote	Additional Context
Access to Healthcare	"The first thing is services being accessible and close by. If someone has to take two buses to get care, they are not going to go."	Highlights how transportation and proximity to resources are major barriers to accessing timely healthcare.
Behavioral Health	"We've had families wait months just to get their child seen by a therapist and that is unacceptable".	Illustrates the shortage and long wait times for pediatric mental health services.
	"It's everywhere – fentanyl is in everything now, and people don't even know what they're taking."	Emphasizes the widespread impact of fentanyl and the dangers of unintentional substance use.
Chronic Disease Prevention and Management	"Access to food and exercise are contributing to things like diabetes and cancer."	Connects chronic disease outcomes to environmental and social factors like nutrition and physical activity.
Maternal and Child Health	"Black babies are twice as likely to die in Cuyahoga County...we have a very significant rate of infant mortality."	This underscores significant differences in infant mortality.

Health-Related Social Needs	"Poverty is the cause of these problems... living in poverty creates stress and that hurts your health."	This succinctly summarizes the foundational role poverty plays in shaping health outcomes. It reflects stakeholder recognition that economic instability is a root cause influencing other critical issues, such as chronic disease, mental health, housing insecurity, and violence. It also reinforces the importance of upstream, systemic solutions in improving community health.

Prioritization Methodology

South Pointe Hospital's 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 differences in areas such as access to care, behavioral health, and chronic disease. 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, South Pointe Hospital 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. South Pointe Hospital is part of the Cleveland Clinic East Submarket which includes South Pointe, Hillcrest, Marymount, Mentor, and Euclid hospitals.

Community Partners and Resources

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

Federally Qualified Health Centers and Health Departments

Federally Qualified Health Centers (FQHCs)[12] are community-based clinics that provide comprehensive primary care, behavioral health, and dental services. In 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 South Pointe Hospital community, community health services are further supported by local public health agencies, including the Cuyahoga County Board of Health. The following FQHC clinics and networks operate in the South Pointe Hospital community:

- Asian Services in Action, Inc.
- Care Alliance
- MetroHealth Community Health Centers
- 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 South Pointe Hospital community:

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

Other Community Resources

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

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

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

- Municipal and Community Services
- Substance Abuse and Other Addictions

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

Comments Received on Previous CHNA

Community Health Needs Assessment reports from 2022 were published on the South Pointe Hospital 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. South Pointe Hospital Community Definition

B. Secondary Data Sources and Analysis

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

C. Environmental Scan and Key Findings

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

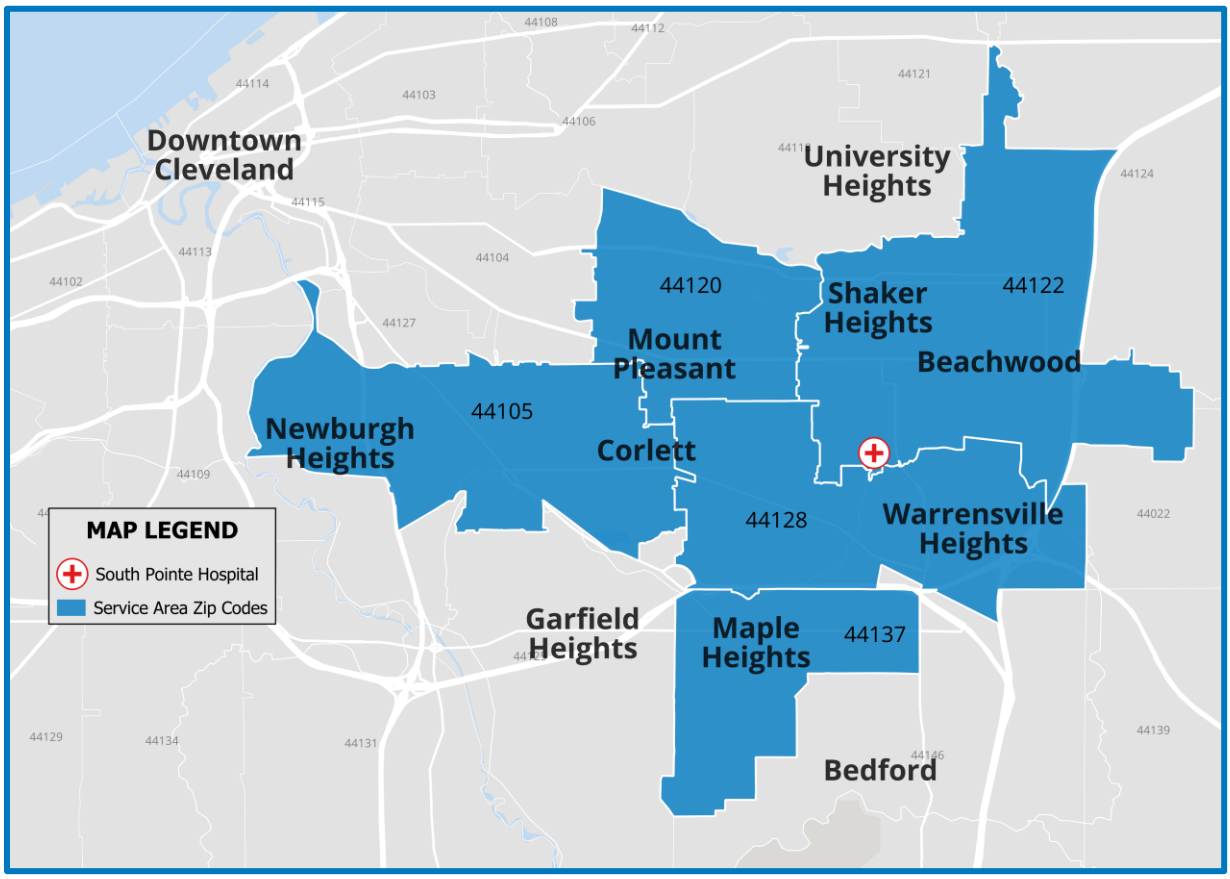
An overview of progress made on the 2022 Implementation Strategies.

F. Acknowledgements

Appendix A: South Pointe Community Definition

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

Figure 9: South Pointe Hospital Community Definition



Appendix B: Secondary Data Sources and Analysis

Secondary Data Sources & Analysis

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

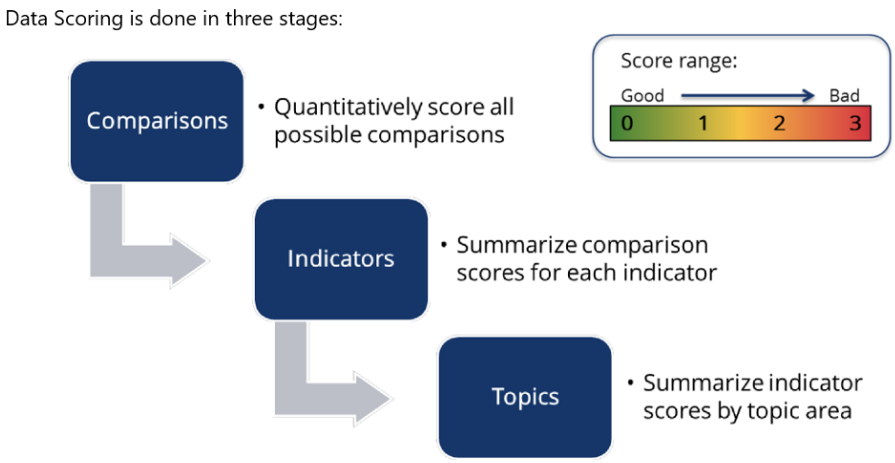
The following is a list of both local and national sources used in the South Pointe Hospital Community Health Needs Assessment:

- American Community Survey
- American Lung Association
- Annie E. Casey Foundation
- CDC - PLACES
- Centers for Disease Control and Prevention
- Centers for Medicare & Medicaid Services
- Claritas Consumer Profiles
- Claritas Consumer Spending Dynamix
- County Health Rankings
- 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 South Pointe Hospital 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 nationwide 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 comparison scores included. 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 Table 3). The highest scoring health topic was *Sexually Transmitted Infections* with a score of 2.04.

Topic Scores

Results from the secondary data topic scoring can be seen in Tables 3 and 4 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 South Pointe Hospital community.

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

Zip Code	CHI Value	FII Value	MHI Value
44105	96.5	97.7	99.7
44120	57.1	87.9	98.7
44122	13.3	35.0	90.6
44128	86.9	97.2	99.7
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 South Pointe Hospital Community.

Figure 12: Census Tract Key (South Pointe Hospital, North)

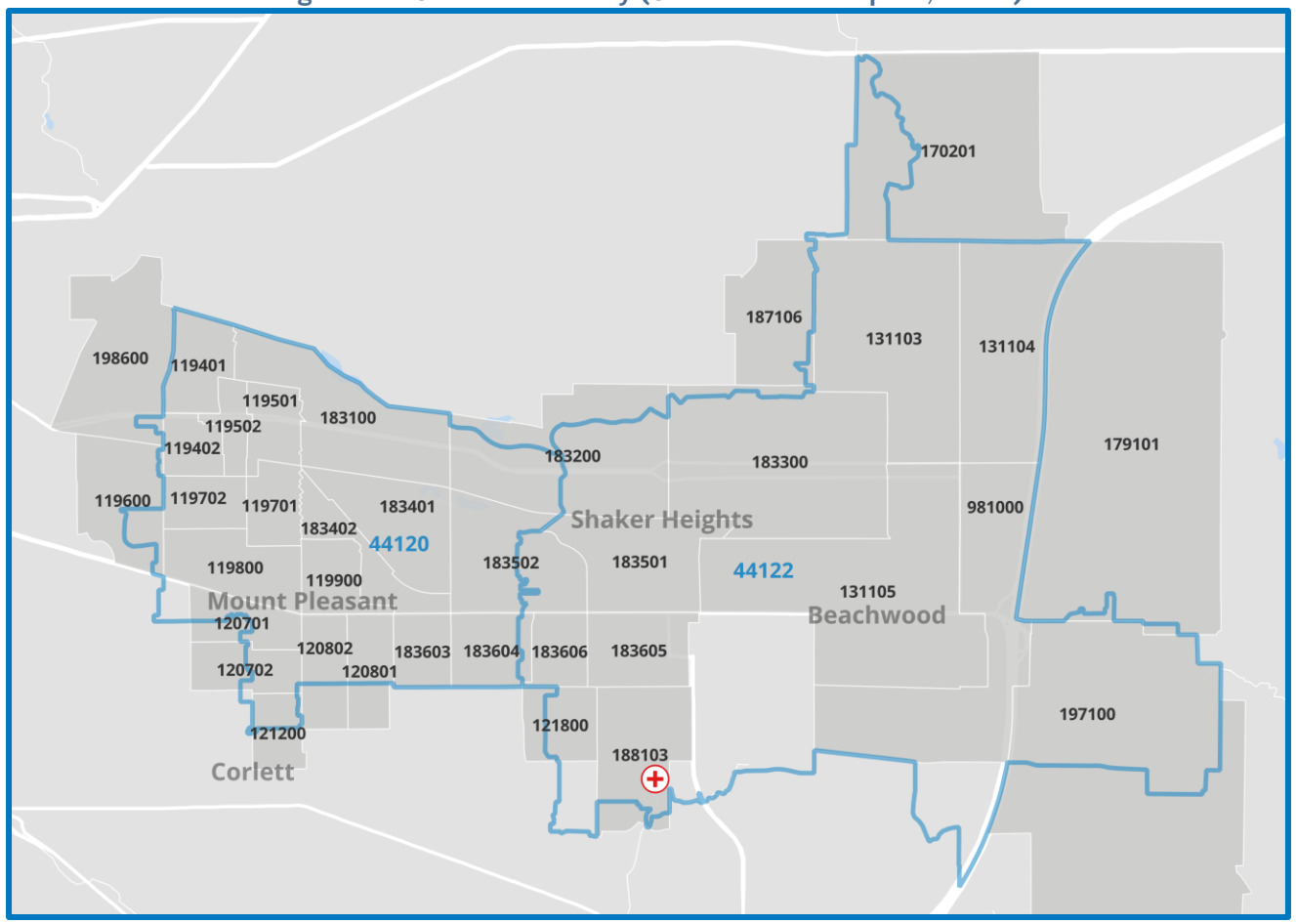


Table 5: Census Tracts by Zip Code (South Pointe Hospital, North)

44120	44122
119401	121800
119402	122100
119501	131103
119502	131104
119600	131105
119701	170201
119702	179101
119800	183200
119900	183300
120600	183501
120701	183502
120702	183604
120801	183605
120802	183606
121100	185203
121200	187106
121700	188103
183100	197100
183200	198300
183401	981000
183402	
183502	
183603	
183604	
183605	
198600	

Figure 13 and Table 6 show the census tracts for each zip code in the southern portion of the South Pointe Hospital Community.

Figure 13: Census Tract Key (South Pointe Hospital, South)

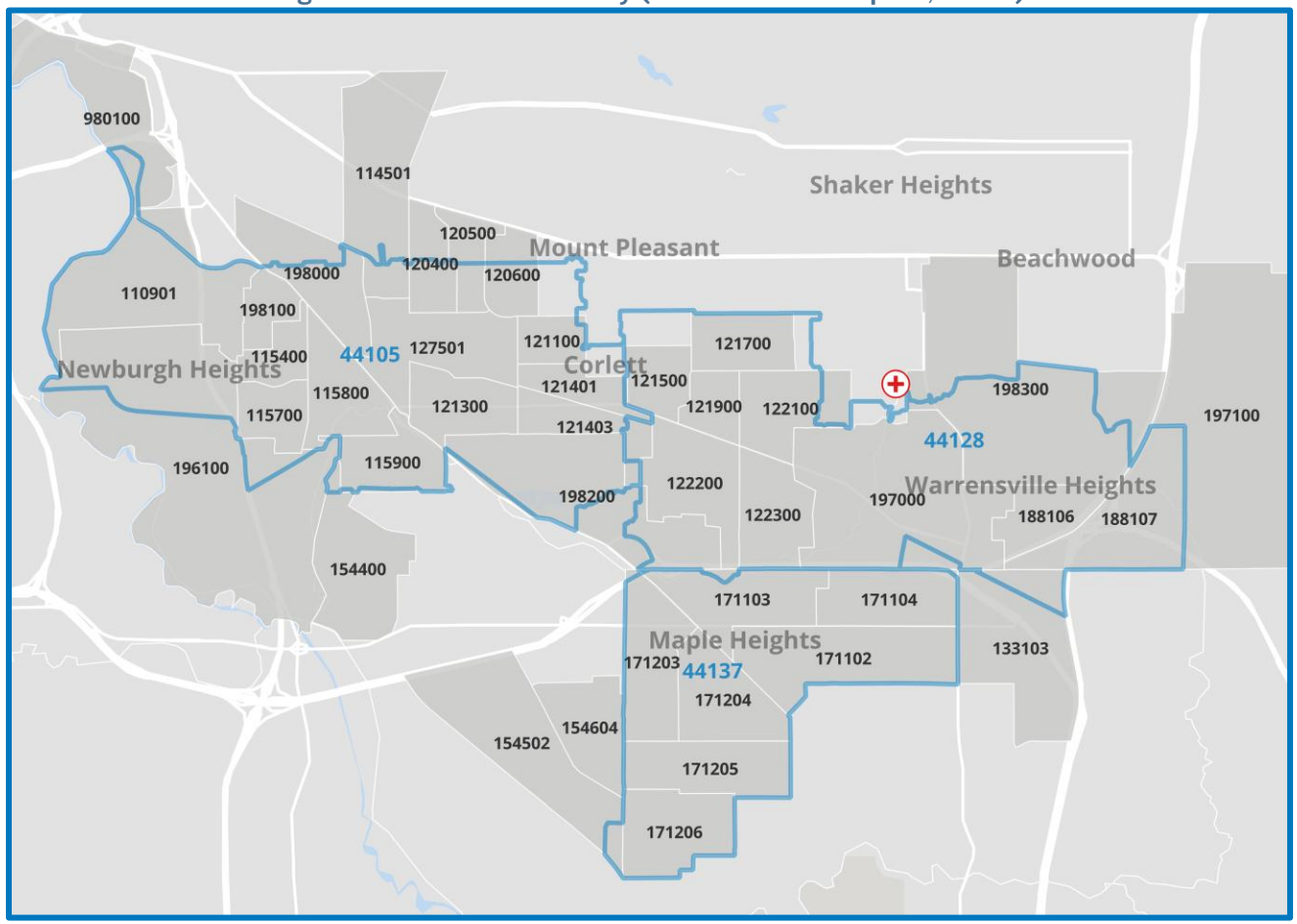


Table 6: Census Tracts by Zip Code (South Pointe Hospital, South)

44105	44128	44137
110901	120702	132100
114501	120801	132302
115400	120802	154502
115700	121200	154604
115800	121401	171102
115900	121403	171103
120400	121500	171104
120500	121700	171203
120600	121800	171204
120701	121900	171205
120702	122100	171206
121100	122200	
121200	122300	
121300	133103	
121401	133104	
121403	171103	
127501	183603	
154200	183604	
154400	188103	
196100	188106	
198000	188107	
198100	197000	
198200	197100	
980100	198200	
	198300	

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

Indicators of Concern for Prioritized Health Needs

Below are details regarding indicators of concern for all prioritized health needs discussed in this report. Each indicator includes a county-level value and standardized score, as well as the following comparison data, where available: state value, national value, state county distribution, national county distribution, and over-time trend. Table 7 describes how to interpret the icons used to describe county distributions and trend data.

Table 7: 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 Spending-to-Income Ratio	*percent*	1.8	--	1.6	1.6			--
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 8 below as a reference key for indicator data sources.

Table 8: 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 Department of Health, Vital Statistics
19	Ohio Department of Health's Ohio Healthy Homes Lead Poisoning Prevention Program
20	Ohio Department 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 9: 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 on Their Way To or From School	*percent*	9.1	*2023*	23
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 South Pointe Hospital Community described in the body of this CHNA report. All data are sourced from Claritas Pop-Facts® (2024 population estimates), unless otherwise noted.

Table 10: Population Size of Hospital Community by Zip Code

Zip Code	Population
44105	32,344
44120	33,198
44122	36,554
44128	26,872
44137	23,002
South Pointe Hospital Community (Total)	151,970

Table 11: Age Profile of Hospital Community and Surrounding Geographies

Age Category	South Pointe Hospital Community	Cuyahoga County	Ohio
0-4	5.7%	5.2%	5.6%
5-9	6.0%	5.4%	5.7%
10-14	6.5%	5.6%	6.1%
15-17	3.9%	3.5%	3.8%
18-20	3.8%	3.9%	4.4%
21-24	4.5%	4.8%	5.3%
25-34	11.7%	13.5%	12.4%
35-44	12.2%	12.7%	12.2%
45-54	11.1%	11.2%	11.7%
55-64	12.7%	13.2%	13.0%
65-74	12.0%	12.1%	11.6%
75-84	6.5%	6.2%	6.1%
85+	3.2%	2.6%	2.2%
Median Age	41.6 years	41.4 years	40.5 years

Table 12: Racial/Ethnic Profile of Hospital Community and Surrounding Geographies

	South Pointe Hospital Community	Cuyahoga County	Ohio	U.S.
White	25.8%	57.3%	75.7%	63.4%
Black/African American	64.9%	29.2%	12.8%	12.4%
American Indian/Alaskan Native	0.2%	0.2%	0.3%	0.9%
Asian	2.5%	3.6%	2.7%	5.8%
Native Hawaiian/Pacific Islander	0.0%	0.0%	0.1%	0.2%
Another Race	1.7%	3.1%	2.1%	6.6%
Two or More Races	4.9%	6.5%	6.4%	10.7%
Hispanic or Latino (any race)	3.5%	7.3%	5.0%	19.0%

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

Table 13: Population Age 5+ by Language Spoken at Home for Hospital Community and Surrounding Geographies

	South Pointe Hospital Community	Cuyahoga County	Ohio	U.S.
Only English	93.0%	88.5%	92.8%	78.0%
Spanish	2.7%	4.3%	2.3%	13.4%
Asian/Pacific Islander Language	1.1%	1.5%	1.0%	3.5%
Indo-European Language	2.3%	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 14: Household Income of Hospital Community and Surrounding Geographies

Income Category	South Pointe Hospital Community	Cuyahoga County	Ohio
Under $15,000	16.2%	12.8%	9.5%
$15,000 - $24,999	11.1%	9.1%	7.8%
$25,000 - $34,999	10.4%	8.7%	8.0%
$35,000 - $49,999	13.6%	12.5%	12.2%
$50,000 - $74,999	15.9%	16.5%	17.0%
$75,000 - $99,999	10.8%	11.9%	13.0%
$100,000 - $124,999	6.5%	8.4%	9.9%
$125,000 - $149,999	4.0%	5.8%	7.0%
$150,000 - $199,999	4.2%	6.2%	7.2%
$200,000 - $249,999	2.1%	3.0%	3.5%
$250,000 - $499,999	3.1%	3.4%	3.4%
$500,000+	2.1%	1.7%	1.6%
Median Household Income	$53,765	$60,568	$68,488

Table 15: Poverty Rates in Hospital Community and Surrounding Geographies

	Families Below Poverty
South Pointe Hospital Community	21.4%
Cuyahoga County	12.2%
Ohio	9.4%
U.S.	8.8%
South Pointe Hospital Zip Codes	.
44105	26.1%
44120	16.8%
44122	6.1%
44128	21.9%
44137	20.1%

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

Table 16: Educational Attainment of Hospital Community and Surrounding Geographies

	South Pointe Hospital Community	Cuyahoga County	Ohio	U.S.
Less than High School Graduate	9.9%	9.3%	8.6%	10.6%
High School Graduate	28.4%	27.2%	32.8%	26.2%
Some College, No Degree	21.7%	20.4%	19.6%	19.4%
Associate Degree	9.4%	8.3%	8.9%	8.8%
Bachelor's Degree	15.0%	20.4%	18.6%	21.3%
Master's, Doctorate, or Professional Degree	15.7%	14.4%	11.5%	13.7%

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

Table 17: 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%
South Pointe Hospital Zip Codes	.
44105	56.1%
44120	48.5%
44122	42.7%
44128	54.9%
44137	45.6%

All values: American Community Survey (2019-2023)

Table 18: Internet Access in Hospital Community and Surrounding Geographies

	Households with Internet
Cuyahoga County	87.5%
Ohio	89.0%
U.S.	89.9%
South Pointe Hospital Zip Codes	.
44105	56.1%
44120	48.5%
44122	42.7%
44128	54.9%
44137	45.6%

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 United Way, hospital systems, and regional health collaboratives, corroborated the relevance of the five prioritized needs in this 2025 CHNA process for South Pointe Hospital.

Across communities, consistent themes emerged: cost barriers and provider shortages limit healthcare access; behavioral health treatment gaps remain significant; chronic disease management is challenged by food insecurity and inadequate recreational infrastructure; 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[13]
- 2023 City of Cleveland Parks and Recreation Community Needs Assessment[14]
- 2024 Cuyahoga County ADAMHS Board Needs Assessment[15]
- 2023 Cuyahoga County Planning Commission Data Book[16]
- 2022 Greater Cleveland LGBTQ+ Community Needs Assessment[17]
- Joint 2022 Cuyahoga County CHNA[18]
- 2023 Livable Cuyahoga Needs Assessment[19]

[13] Ohio Department of Health. (2023). *Ohio State Health Assessment 2023*. Ohio University; Ohio Department of Health. Retrieved from Ohio Department of Health website.
[14] 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
[15] 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
[16] 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?
[17] 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
[18] 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
[19] 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 and reduction of barriers? (Equal Access is the idea that everyone should have the same chance to be healthy, regardless of their circumstances)**

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

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

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

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

CLOSURE SCRIPT: Thank you again for taking time out of your busy day to share your experiences with us. We will include the key themes from today's discussion in our

assessment. Please remember, your name will not be connected to any of the comments you made today. Please let us know if you have any questions or concerns about this.

Community Input Key Findings

Community stakeholders from a total of 18 organizations provided feedback for the South Pointe Hospital 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 South Pointe Hospital community:

- ADAMHS Board of Cuyahoga County
- ASIA (Asian Services In Action)
- Benjamin Rose Institute on Aging
- Boys and Girls Clubs of Northeast Ohio
- City of Cleveland Department of Public Health
- City of Cleveland, Division of Fire
- City of Warrensville Heights
- Cleveland Clinic Children's
- Cuyahoga Community College-East
- 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
- Mt. Zion of Oakwood
- NAMI Greater Cleveland

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

Access to Healthcare

Stakeholder interviews conducted for the South Pointe Hospital 2025 CHNA revealed persistent challenges in ensuring equal access to care across the community. Participants described a range of barriers that limit residents' ability to obtain timely, affordable, and appropriate services, issues that were especially pronounced for low-income households and older adults. Transportation limitations, high out of pocket costs, and the lack of culturally and linguistically responsive care emerged as recurring concerns.

Even with health insurance, many residents struggle to navigate a complex healthcare system or to afford essential medications, follow up appointments, and specialty care.

Stakeholders emphasized that these barriers not only delay treatment but also contribute to worsening health outcomes and increased reliance on emergency departments. Several participants underscored the need for more integrated or co-located service models that bring medical, behavioral, and social support together in one setting. Others stressed the importance of fostering long-term, trusting relationships between patients and providers, particularly for populations that have historically experienced differences in healthcare access and health outcomes.

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

- Transportation limitations: Stakeholders cited lack of reliable transportation or complex transit routes as a major barrier, particularly for individuals in outlying neighborhoods or those with disabilities.
- Affordability despite insurance coverage: Even with Medicaid or other forms of insurance, many community members still struggle to afford co-pays, prescriptions, and follow-up visits.
- Limited access to culturally responsive care: There is a need for providers who reflect the cultural and linguistic differences of the community and who understand the lived experiences of the populations they serve.
- Desire for integrated, wraparound services: Participants expressed a strong interest in models of care that address physical health, behavioral health, housing, nutrition, and other social needs in one setting.
- Continuity and trust in care providers: Building long-term, trusting relationships with care providers was seen as essential for encouraging regular engagement with the healthcare system.

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

"Transportation is a huge challenge. Even if there's care available, people can't always get there."

"Even with insurance, families are still deciding between paying for their prescriptions or putting food on the table."

"We need to stop assuming that one-size-fits-all. Communities need care that respects their culture, language, and experience."

"Trust is everything. If someone doesn't feel seen or heard by their provider, they won't come back."

Community input reaffirmed that access to quality, affordable healthcare is a pressing and multifaceted issue for the South Pointe Hospital community. Residents face compounding barriers, including cost, distance, limited provider availability, and lack of culturally informed services, which affect their ability to engage in preventive care and manage chronic conditions. For certain communities, the absence of trust and continuity further exacerbates health differences. These insights highlight the need for patient-

centered strategies that integrate health and social services, prioritize cultural responsiveness, and remove logistical and financial barriers to care.

Behavioral Health: Mental Health and Substance Use Disorder

Stakeholder feedback revealed that behavioral health, encompassing both mental health and substance use disorder, remains a deeply entrenched concern in the South Pointe Hospital community, affecting residents of all ages. Participants noted that these challenges have been magnified in recent years by the prolonged effects of the COVID-19 pandemic, coupled with social isolation, trauma, and ongoing economic pressures. Mental health and substance use issues were frequently linked to broader community conditions such as housing instability, poverty, and insufficient social support, which can both trigger and exacerbate behavioral health needs. Access to care is hindered by persistent provider shortages, pervasive stigma, and the limited availability of culturally responsive services, leaving many individuals without timely, adequate, or appropriate treatment.

The following are highlights of participant feedback regarding behavioral health:

- Increased mental health needs post-pandemic: Anxiety, depression, and trauma-related concerns have become more prevalent across all age groups, especially among youth and older adults.
- Persistent provider shortages: Stakeholders highlighted long wait times and a lack of behavioral health professionals as major access issues.
- Substance misuse, particularly opioids and fentanyl, is a growing crisis: There is an urgent need for expanded prevention, treatment, and harm reduction efforts.
- Limited behavioral health services that are culturally aware: Language barriers and lack of culturally sensitive care discourage engagement in mental health or addiction services.
- Stigma continues to be a barrier: Fear of judgment prevents individuals from seeking help for both mental health and substance use.
- Need for school-based and community-centered support: Participants emphasized the value of meeting individuals where they are, particularly through trusted local institutions.

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

"We're seeing a significant increase in mental health issues, especially among kids and teens, but the resources just aren't there to keep up."

"There are very few places where people can go that feel safe, judgment-free, and actually accessible."

"Substance use is still rampant, and fentanyl has made it so much more deadly. We need to expand our harm reduction and recovery supports."

"Mental health and substance use have to be addressed together. You can't treat one without the other."

Stakeholders reinforced that behavioral health is a foundational component of overall health and community wellbeing. The need for expanded, integrated, and culturally appropriate services was a recurring theme across interviews. From mental health therapy to substance use recovery, participants described a system that remains fragmented, under-resourced, and difficult to navigate. To meet the growing demand and reduce stigma, respondents called for accessible, community-based solutions that support early intervention, long-term engagement, and wraparound care. Addressing behavioral health more holistically will be essential to improving outcomes for individuals and families across the South Pointe Hospital community.

Chronic Disease Prevention & Management

Stakeholder discussions on chronic disease prevention and management in the South Pointe Hospital community underscored the complex mix of factors contributing to the onset and progression of conditions such as diabetes, heart disease, and other long-term illnesses. Participants cited poor nutrition, limited access to preventive care, and challenges with consistent disease management as key drivers of poor outcomes. Many emphasized that effective prevention and management must be rooted in a holistic, community focused approach, one that combines health education, early screening, and reliable access to ongoing care. Targeted strategies for older adults and under resourced populations were seen as essential, given the heightened barriers these groups face in maintaining wellness and managing chronic conditions over time.

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

- Residents in lower-income neighborhoods face limited access to affordable, nutritious foods and fresh produce.
- Poor dietary choices are often driven by lack of education, time, or resources rather than lack of interest in healthy eating.
- There is a desire for more community gardens, farmers markets, and culturally appropriate wellness education.
- Stakeholders noted the need for physical activity programs and recreational spaces that are safe, accessible, and affordable.

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

"Access to healthy food should not be a privilege. It should be the standard."

"You cannot talk about managing diabetes if someone doesn't even have a grocery store nearby."

Cancer
The following are highlights of participant feedback regarding cancer:

- Preventive screenings are underutilized due to affordability, access barriers, and lack of awareness.
- Community health fairs and screening events were described as valuable but not sufficient for ongoing cancer prevention.
- Differences in cancer outcomes across groups highlight the need for targeted education and outreach.

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

"People don't think about cancer screenings until it's too late. We have to meet them where they are."

"If you don't have insurance or a regular doctor, something like a mammogram can feel out of reach."

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

- Chronic diseases are often detected late, and many are poorly managed due to lack of consistent care and follow-up.
- Stakeholders expressed concern about health literacy and the ability of patients to manage conditions between visits.
- Medication affordability and dietary limitations were identified as barriers to effective disease management.

These findings highlight the urgent need for both prevention and sustained management strategies for chronic diseases, tailored to address social drivers of health, differences in health outcomes, and early detection.

The following is a selection of quotes from key informants about diabetes, heart disease, stroke, and other chronic conditions:

"A lot of people are finding out they have high blood sugar or pressure at community events. That's their first interaction with healthcare."

"You can't manage a chronic condition without consistent care and education."

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

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

- Older adults are particularly suspectable to chronic disease and face additional challenges like mobility limitations and isolation.
- Many seniors do not have regular access to transportation or a caregiver to support their healthcare needs.
- There is a need for aging-in-place support and tailored outreach that considers physical, cognitive, and emotional health.

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:

"We have seniors who skip appointments because they can't get a ride or don't have anyone to go with them."

"Managing multiple chronic conditions is overwhelming, especially when you're doing it alone."

Stakeholders across the South Pointe Hospital community emphasized that chronic disease prevention and management requires coordinated, accessible, and community-informed solutions. From nutrition and wellness to cancer screenings and chronic disease care, individuals face numerous barriers that prevent them from achieving better health outcomes. These barriers are particularly pronounced for older adults, individuals with limited income, and those without stable access to primary care. The findings reinforce the need for expanded prevention efforts, integrated care models, and services that address both clinical needs and the social conditions that influence health.

Maternal and Child Health

The following highlights key insights from stakeholder interviews regarding maternal and child health in the community South Pointe Hospital serves. Participants consistently raised concerns about differences in maternal care, gaps in prenatal and postpartum support, and growing mental health needs among children and adolescents. These issues are shaped by broader systemic and social factors, including access to transportation, behavioral health services, and providers who are culturally aware. Stakeholders emphasized the importance of coordinated family-centered care that supports both parents and children throughout critical stages of development.

The following are highlights of participant feedback regarding maternal and child health:

Maternal, Fetal & Infant Health

- Access to prenatal care remains inconsistent, especially for uninsured or underinsured individuals.

- Transportation, housing instability, and mental health concerns complicate pregnancy and postpartum health.
- Participants identified a need for wraparound services such as doulas, home visiting programs, and peer support.
- Postpartum depression and anxiety are underdiagnosed and undertreated due to stigma and limited behavioral health access.

Children's Health

- Behavioral and emotional health challenges among children have grown, especially since the pandemic.
- There is a shortage of pediatric behavioral health providers and long wait times for services.
- Access to school-based support and early childhood development programs is uneven across the community.
- Nutrition, physical activity, and safe environments were noted as key elements of child wellness.
- Concerns about lead poisoning and its impact on child development were highlighted, along with a need for prevention and education.

These insights underscore an urgent need for community-rooted approaches to maternal and child health that address both clinical care and the social conditions shaping health outcomes.

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

"We have moms skipping appointments because they can't get childcare or don't have a ride."

"There is still a lot of stigma around postpartum mental health. It makes it harder for women to ask for help."

"Doulas and community health workers are making a huge difference, but we need more of them."

"Kids are struggling emotionally, and schools are overwhelmed. The mental health piece is urgent."

"We need more consistent access to school nurses, counselors, and afterschool programs."

"Families want to do what's best for their children, but they need more support and fewer barriers."

In summary, stakeholders reinforced that maternal and child health is a critical focus area that requires early intervention, consistent care, and community-based support. Addressing the social and structural barriers that affect pregnancy, birth outcomes, and

child development is essential to improving equal access to care in the South Pointe Hospital community. From mental health services to nutrition and education, families need access to trusted providers and systems that are responsive to their lived realities. Investing in maternal and child health not only improves individual outcomes but also strengthens the long-term wellbeing of the entire community.

Health-Related Social Needs

The following highlights key insights from stakeholder interviews regarding health-related social needs in the community South Pointe Hospital serves. Participants emphasized that social and economic challenges, including housing instability, transportation barriers, and limited access to education and jobs, are deeply connected to health outcomes. Stakeholders described how these issues limit residents' ability to access healthcare, maintain stable employment, and support healthy lifestyles. Interviewees also pointed to differences in health outcomes that reflect historical and ongoing differences, particularly for low-income communities and communities of color. Addressing these root causes of health requires collaborative, upstream strategies that prioritize long-term community wellbeing.

Prevention & Safety

- Concerns about youth violence and community safety were linked to a lack of structured, safe spaces for children and teens.
- Stakeholders expressed a need for more afterschool programs, mentorship, and prevention-focused community engagement.

Quality of Life (Community, Economy, Education)

- Access to clean, safe neighborhoods and green space was cited as essential for mental health and community pride.
- A sense of connection to the community was described as a protective factor for wellness.

Community Infrastructure and Engagement

- Transportation barriers limit access to healthcare, employment, and education.
- Participants supported infrastructure investments that improve mobility and access for under resourced neighborhoods.

Economic Opportunity and Stability

- Job insecurity, underemployment, and rising housing costs were identified as core stressors affecting families' health.
- Participants called for more job training programs and access to living wage employment.

Education as Foundation for Well-being

- Education was described as a critical determinant of long-term health and opportunity.
- Differences in school quality and access to enrichment activities continue to create gaps in achievement and stability.

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

"If someone has to take two buses to get to a job or a doctor, that is already a barrier to health."

"Families are doing their best, but when rent, food, and gas keep rising, something has to give."

"Our kids need more than academics. They need safe spaces, mentors, and schools that see the whole child."

"People want to feel connected to where they live. That starts with clean neighborhoods and spaces where people feel safe."

Overall, stakeholder feedback makes clear that health-related social needs are a foundational driver of health and wellbeing across the South Pointe Hospital community. Economic instability, transportation gaps, differences in education, and limited access to safe community spaces all contribute to differences in health outcomes. These challenges are deeply rooted and require coordinated action across sectors, with a focus on equal investment in housing, education, infrastructure, and employment. Community members and leaders alike called for more upstream, systems-level solutions that reflect the lived experiences of those most affected. Addressing these issues is essential to creating healthier, more stable communities.

Appendix E: Impact Evaluation

Actions Taken Since Previous CHNA

South Pointe Hospital's previous Implementation Strategy Report (ISR) outlined a plan for addressing the following priorities identified in the 2022 CHNA: Access to Healthcare, Behavioral Health, Chronic Disease Prevention and Management, 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 secure online and mobile platforms, South Pointe Hospital connected patients with Cleveland Clinic providers for telehealth and virtual visits. In 2024, Cleveland Clinic provided 1.1 million virtual visits.

C. South Pointe Hospital launched a hospital Resource Center in 2024, supported by First Federal of Lakewood Bank, to provide health education, physical activity, and attention to social drivers of health. The Resource Center provided health and digital literacy education on skills to access MyChart access, schedule appointments, request refills, track lab results, and complete virtual visits.

D. 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. Cleveland Clinic continued to provide preventative education and share evidence-based practices.

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

C. The hospital partnered with Alcoholics Anonymous (AA), National Alliance on Mental Illness (NAMI), and Beyond Abuse (for victims of violence) to offer support programs. South Pointe partnered with Ohio Guidestone to provide in-service for school staff related to de-escalation in the classroom, and taking care of mental health issues.

Chronic Disease Prevention and Management

Actions and Highlighted Impacts:

A. South Pointe's new Resource Center provided ongoing health education services. The Heart Vascular Thoracic Institute and Taussig Cancer Center provided screenings for cancer, heart, and other chronic disease issues. Stroke Education was provided to community residents at the library and local senior centers. Taussig Cancer Community Outreach team offered resource education. A Mammogram Clinic was provided in May 2024.

B. The hospital's Resource Center launched a Nourish Pantry in 2024 that served over 400 households and provided health and nutrition education. In 2023 – 24 the mobile food pantry distributed food to 8,000 households.

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 Forces 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. Through Cleveland Clinic's Center for Infant and Maternal Health, the hospital continued to provide services for at-risk pregnant women to improve their health and support 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 support for the *Centering Pregnancy* group prenatal care model to expecting mothers and increased the number of families who participate in evidence-based home visiting programs.

Health-Related Social Needs

Actions and Highlighted Impacts:

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

B. 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. This initiative is part of our larger $10.4 million commitment to address food insecurity across our communities by helping families access the resources they need to thrive.

C. South Pointe Hospital provided supply-filled backpacks and books at the YMCA and community library to support K-12 students. The hospital partnered with the YMCA and Ohio Department Health to ensure students had required vaccinations.

D. The hospital supported community residents with home beautification through the annual *Neighbors Helping Neighbors* project.

E. South Pointe Hospital opened a new community pharmacy in 2025. Eastern suburbs of Cuyahoga County, including areas around South Pointe Hospital, now face “pharmacy deserts” with limited access to essential medications and pharmacist services. Limited pharmacy access can lead to difficulties in filling prescriptions, following care plans and managing chronic conditions. The South Pointe Hospital pharmacy aims to bridge this gap in care for Warrensville Heights and surrounding communities.

F. South Pointe Hospital provided workforce development resources and training including interviewing techniques and resume writing. The hospital hosted community tours and career fairs.

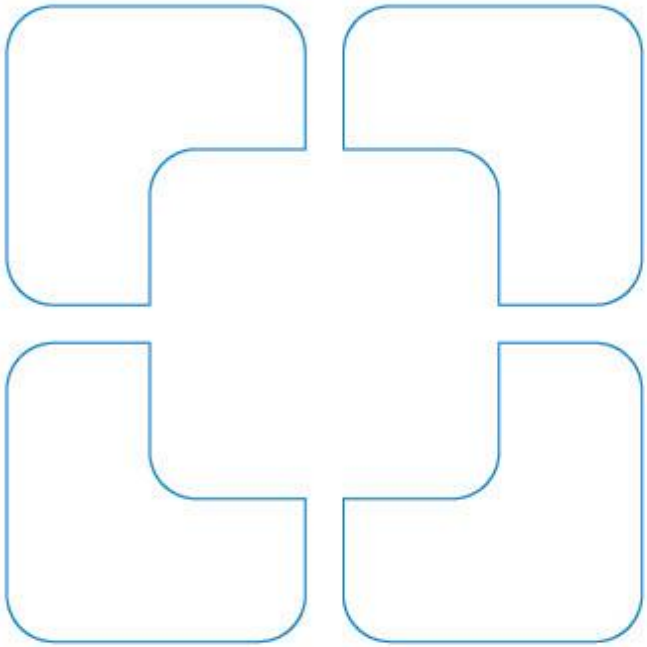
G. Cleveland Clinic’s Center for Youth and College Education provided youth and college learners with career exploration opportunities in a healthcare environment, offering programming that prepares the next generation of caregivers to join the healthcare workforce.

Appendix F: Acknowledgements

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

Authors for this report include:

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



clevelandclinic.org/**CHNAreports**

25-CDC-6446158