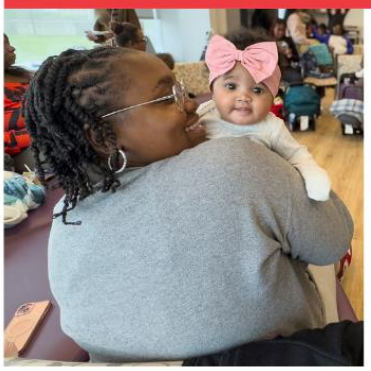
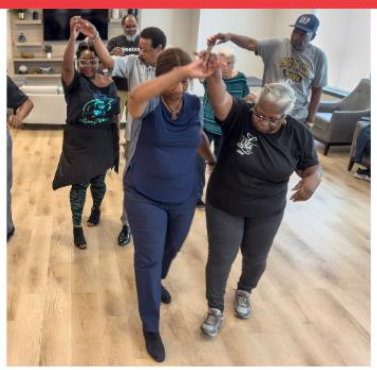
Community Health Needs Assessment

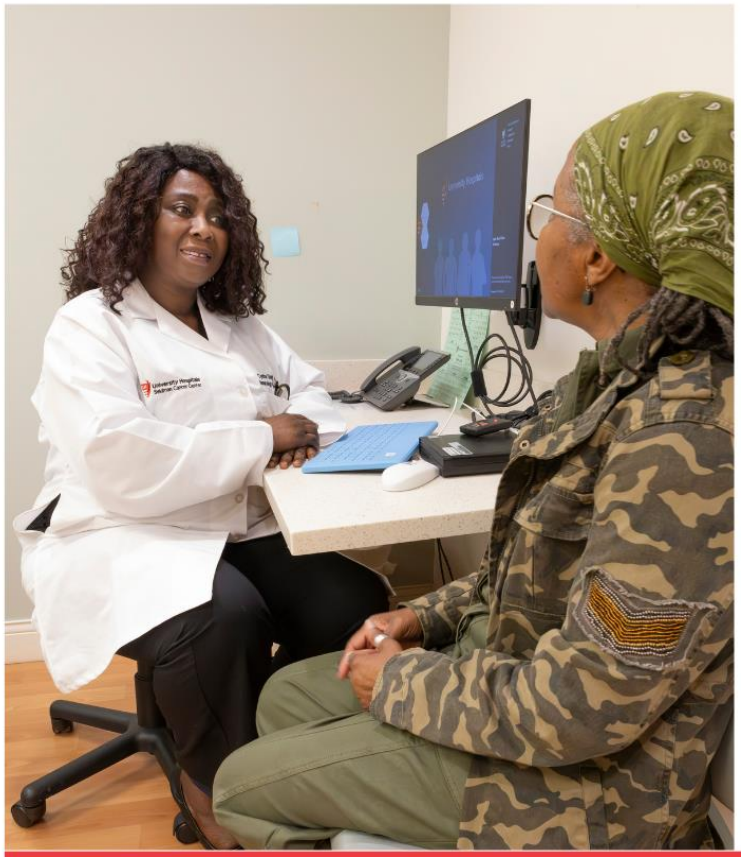
2025

Cuyahoga County

University Hospitals







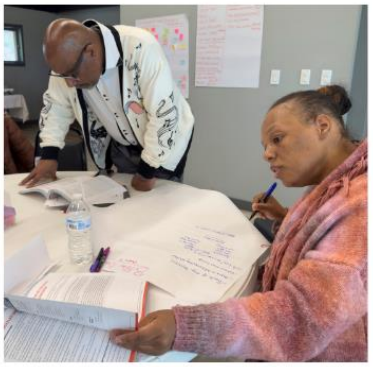


Table of Contents

Foreword 3
Introduction and Purpose 4
Acknowledgments 7
About University Hospitals (UH) 8
Defining Community 11
CHNA at a Glance 12
Evaluation Progress Since Prior Report 16
Demographics of Cuyahoga County 19
Social Determinants of Health 24
Data Collection Methodology and Key Findings 35
Data Considerations 40
Identification of Significant Health Needs 41
Prioritization of Significant Health Needs 44
Prioritized Health Needs 47
Other Health Needs of Concern 73
Other Findings Impacting Health 89
Conclusions 91
Appendices 92

Introduction and Purpose

University Hospitals (UH) is pleased to present its 2025 Community Health Needs Assessment (CHNA) for Cuyahoga County. As federally required by the Affordable Care Act (ACA) commonly known as Obamacare, this report provides an overview of the methods and processes used to identify and prioritize significant health needs. UH partnered with the Conduent Healthy Communities Institute (HCI) to conduct the 2025 CHNA.

This report aims to provide a clear and meaningful understanding of the most urgent health needs within the defined UH service area. The data will serve as a foundation or building block to inform and guide future strategic planning, along with resource allocation to the communities greatest health care needs. Special attention has been given to the needs of vulnerable populations, unmet health needs or gaps in services, and input from the community.

Findings from this report will be used to identify, develop, and target UH initiatives to provide and connect patients with resources to improve these health challenges in the community. The 2025 CHNA is compliant with the requirement set forth by Treas. Reg. §1.501(r) ("Section 501(r)") and serves as the 2025 Community Health Needs Assessment ("CHNA") for the following hospitals:

- UH Ahuja Medical Center
- Beachwood RH, LLC (UH Rehabilitation Hospital)
- UH Beachwood Medical Center
- UH Cleveland Medical Center
- UH Parma Medical Center
- UH Rainbow Babies & Children's Hospital
- UH St. John Medical Center

This report includes a description of:

- The community demographic and population served;
- The process and methods used to obtain, analyze, and synthesize primary and secondary data;
- The significant health needs in the community, taking into account the needs of uninsured, low-income, and marginalized groups;
- The process and criteria used in identifying certain health needs as significant and prioritizing those significant community needs.

2023 Ohio State Health Assessment (SHA)

The 2023 Ohio State Health Assessment (SHA) provides data needed to inform health improvement priorities and strategies in the state. This assessment includes over 1,800 Ohioans, representing every county in the state, who participated in a discussion group or completed a survey, and the review of over 200 hospital and health department needs assessments.

Similar to the 2023 Ohio SHA, the 2025 University Hospital Community Health Needs Assessment (CHNA) examined a variety of metrics from various areas of health including, but not limited to, health behaviors, chronic disease, access to healthcare, and social determinants of health. Additionally, the CHNA studied themes and perceptions from local stakeholders from a wide variety of sectors.

The top health priorities identified during the 2023 Ohio SHA for hospitals were:

- Mental Health
- Substance Use
- Obesity/nutrition/inactivity
- Chronic disease
- Access to care

The interconnectedness of Ohio's greatest health challenges, along with the overall consistency of health priorities identified in this assessment, indicates many opportunities for collaboration between a wide variety of partners at the state and local level, including physical and behavioral health organizations and sectors beyond health. It is our hope that this CHNA will serve as a foundation for such collaboration. To view the full 2023 Ohio State Health Assessment, please visit: https://odh.ohio.gov/about-us/state-health-assessment

Acknowledgments

Thank you to the dedicated individuals from the following organizations who gave generously of their time and expertise to help guide the development of the 2025 Community Health Assessment Plan (CHNA) for Cuyahoga County.

• Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Board of Cuyahoga County	• Greater Cleveland Food Bank
• ASIA (Asian Services In Action)	• Lead Safe Cleveland Coalition
• Benjamin Rose Institute on Aging	• LGBT Community Center of Greater Cleveland
• Birthing Beautiful Communities	• NAMI Greater Cleveland
• Boys and Girls Club of Northeast Ohio	• Neighborhood Family Practice (FQHC)
• City of Cleveland Department of Public Health	• Positive Education Program (PEP)
• Cuyahoga County Board of Health	• Project Noir
• Cuyahoga Metropolitan Housing Authority	• Thirdspace Action Lab
• Esperanza	• Towards Employment
• First Year Cleveland	

The 2025 CHNA for Cuyahoga County is aligned with the efforts of both the Cuyahoga County Board of Health (CCBH) and the Cleveland Department of Public Health (CDPH).

About University Hospitals (UH)

Founded in 1866, University Hospitals serves the needs of patients through an integrated network of more than 20 hospitals (including five joint ventures), more than 50 health centers and outpatient facilities, and over 200 physician offices in 16 counties throughout northern Ohio. The system's flagship quaternary care, academic medical center, University Hospitals Cleveland Medical Center, is affiliated with Case Western Reserve University School of Medicine, Northeast Ohio Medical University, Oxford University, Taiwan National University College of Medicine and the Technion Israel Institute of Technology. The main campus also includes the UH Rainbow Babies & Children's Hospital, ranked among the *Top Children's Hospitals In The Nation By US News*; UH MacDonald Women's Hospital, Ohio's only hospital for women; and UH Seidman Cancer Center, part of the NCI-designated Case Comprehensive Cancer Center.

Mission, Vision & Values

Mission: Why we are here
To Heal. To Teach. To Discover.

Vision: What we want to do
Advancing the Science of Health and the Art of Compassion.

Values: What we believe

UH is home to some of the most prestigious clinical and research programs in the nation, with more than 3,000 active clinical trials and research studies underway. UH Cleveland Medical Center is perennially among the highest performers in national ranking surveys, including "America's Best Hospitals" from U.S. News & World Report. UH is also home to 19 Clinical Care Delivery and Research Institutes. UH is one of the largest employers in Northeast Ohio with more than 30,000 employees. Follow UH on LinkedIn, Facebook and Twitter. For more information, visit UHhospitals.org.

Strengthening our Communities

Improving the health and well-being of our community is at the heart of who we are at University Hospitals. Everything we do is driven by a commitment to better care for the people in Northeast Ohio. We begin by listening – learning from the voices and experiences of the communities we serve. One of the ways we do this is through our Community Health Needs Assessments. By collaborating with community partners including local health departments, we identify the most pressing health challenges facing each of our hospital's communities. This insight allows us to focus our resources where they can make the greatest impact.

UH is making community health investments through comprehensive efforts that include both clinical and non-clinical approaches. This encompasses education and programming, advocacy, and strategic partnerships. By working closely with caring organizations across the region, we aim to address health needs collaboratively, recognizing that no single entity can do this work alone. Through these combined efforts, we strive to strengthen community resources and reduce health disparities, creating a healthier future for all.

University Hospitals is dedicated to the communities it serves. There is a CHNA conducted in every county in UH's footprint to understand and plan for the health needs of patients and residents.

Consultants

University Hospitals (UH) commissioned Conduent Healthy Communities Institute (HCI) to support report preparation for its 2025-2028 CHNA. 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. The following HCI team members were involved in the development of this report: Era Chaudhry, MPH MBA- Public Health Consultant, Adrian Zongrone, MPH- Senior Data Analyst, Irene Ortiz, Communications BA – Delivery Management Analyst.

To learn more about Conduent HCI, please visit https://www.conduent.com/healthcarebusiness-solutions/community-health-solutions/.

Written Comments

University Hospitals solicited feedback on the joint 2022 Cuyahoga County Community Health Needs Assessment, which is posted on its website, but did not receive any comments. Individuals are encouraged to submit written comments, questions, or other feedback about University Hospitals' strategies to CommunityBenefit@UHhospitals.org. Please make sure to include the name of the University Hospitals Facility that you are commenting about, and if possible, a reference to the appropriate section within the document.

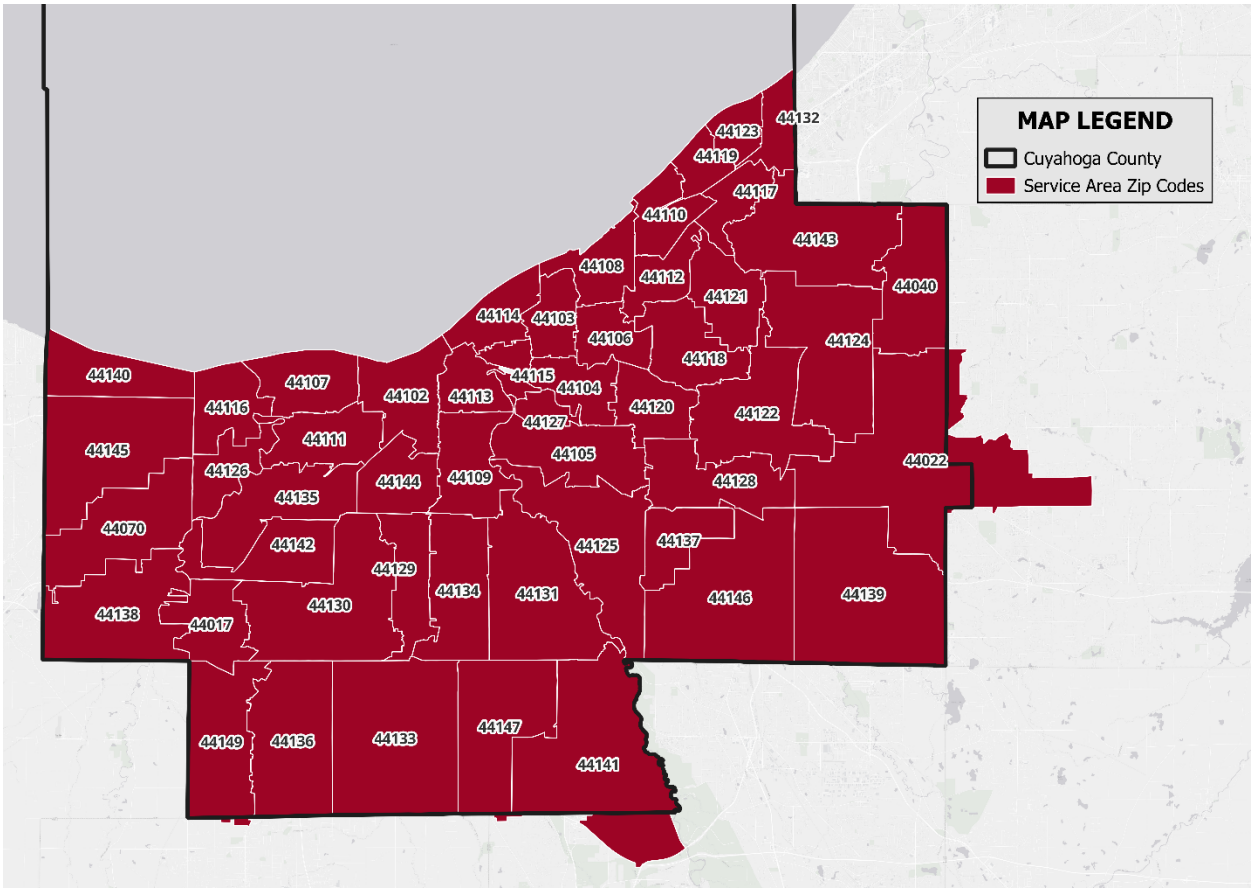
Board Adoption

University Hospitals Board adopted the 2025 Cuyahoga County Community Health Needs Assessment (CHNA) on September xx, 2025. The 2025 Cuyahoga County CHNA is available at: uhhospitals.org/CHNA-IS

Defining Community

Defining the community is a crucial step in the Community Health Needs Assessment (CHNA) process, as it establishes the framework for both the assessment and the development of targeted implementation strategies. For the purposes of this CHNA, the community served by University Hospitals (UH) is defined as Cuyahoga County, Ohio. The geographical scope of the service area is outlined by 51 zip codes, highlighted in red on the map below. This area includes a population of approximately 1,228,231 residents, whose health needs and outcomes are the focus of this collaborative effort. By clearly defining these boundaries, CHNA ensures a comprehensive approach to identifying and addressing the health priorities of the county.

FIGURE 1: UNIVERSITY HOSPITALS SERVICE AREA



Community Health Needs Assessment - At a Glance

Cuyahoga County Overview

1,228,231
Population

41.4 years
Median Age

$60,568
Median Household Income

12.2%
Families Below the Federal Poverty Level

57.3%
White

29.2%
Black

11.5%
Language Other than English Spoken

4.3%
Spanish Spoken

Data Methodology

Data Scoring

Data was collected from 29 secondary data sources . 150 demographic, social, economic, and health indicators were available for Cuyahoga County.

Key Informants

19 phone interviews with community experts were taken to gather information on the health needs of vulnerable populations, available resources, and barriers to accessing care.

Priority Areas

Chronic Disease

Maternal and Child Health

Wellbeing

For more information about the significant health topics please refer Identification of significant health needs section of this report.

Chronic Disease

Themes from Interviews

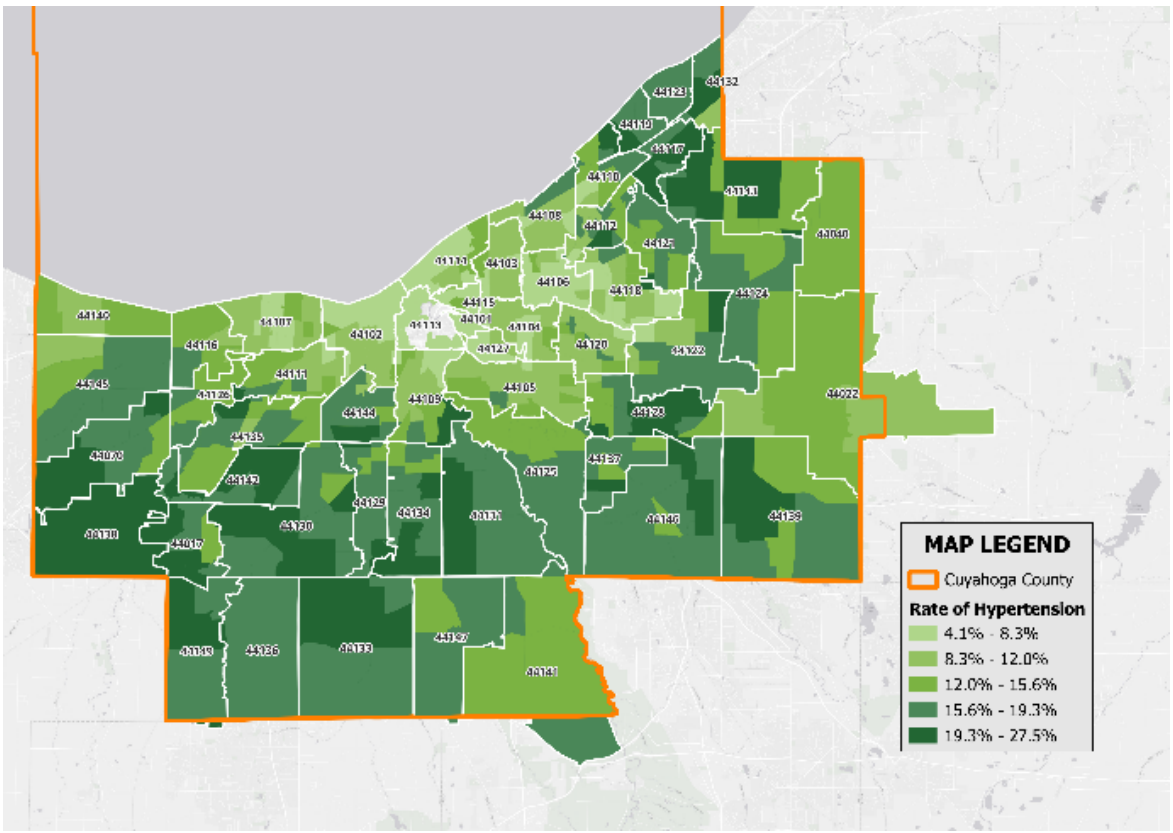
- Chronic diseases are widespread, with heart disease and diabetes being the most cited.
- Outcomes vary significantly by race, income, and neighborhood.
- Causes: Poverty, food deserts, lack of preventative care, and inactive lifestyle.

Indicators of Concern

Diabetes

- In 2021, one in ten Cuyahoga adults (9.9%) had been diagnosed with either type 1 or type 2 diabetes. (Source: CDC)
- In 2024, the highest rate of UH patients with diabetes was in zip code 44117 (Euclid).

ESTIMATED RATE OF DIABETES AMONG ALL INDIVIDUALS IN CUYAHOGA COUNTY



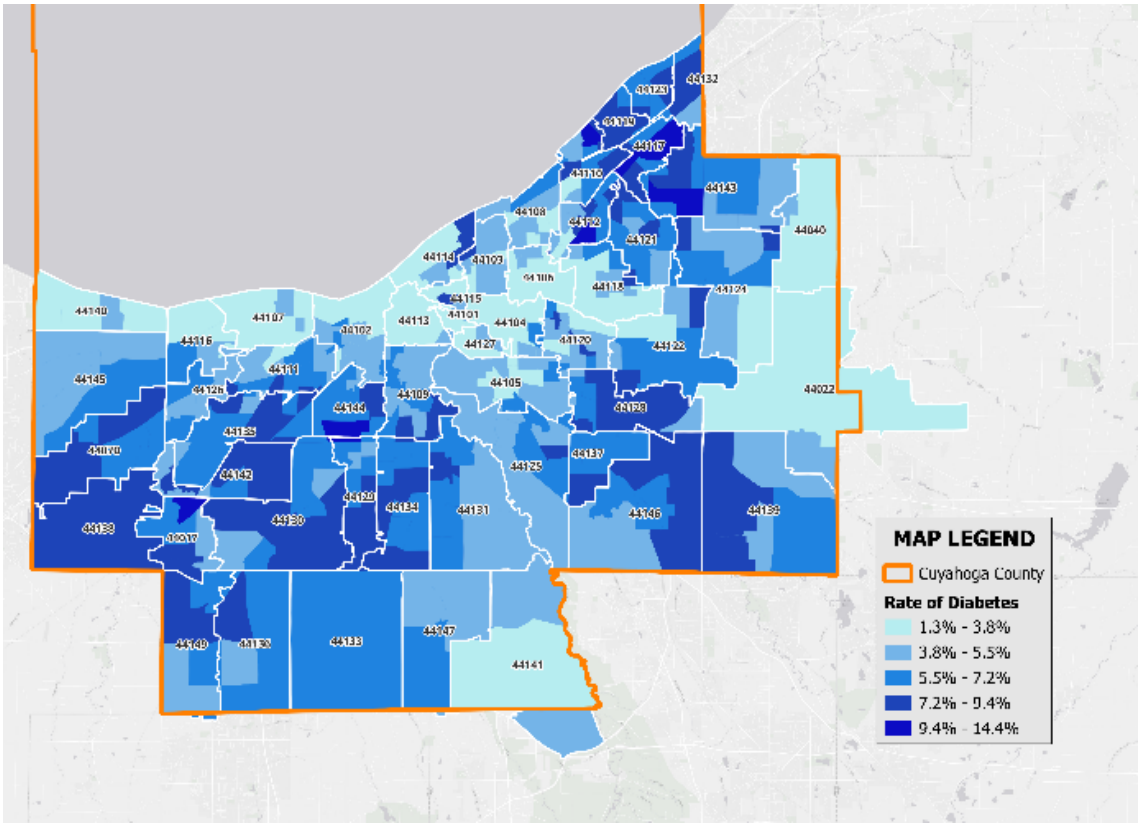
Chronic Disease

Indicators of Concern

Blood Pressure

- In 2023, 6.0% of Medicare enrollees in Cuyahoga were treated for a stroke. (Source: Centers for Medicare & Medicaid Services)
- In 2024, the highest rate of UH patients treated for a stroke was in zip code 44122 (Beachwood).

ESTIMATED RATE OF HYPERTENSION AMONG ALL INDIVIDUALS IN CUYAHOGA COUNTY



Maternal and Child Health

Themes from Interviews related to Maternal Health

- Maternal health is a major concern, mainly linked to chronic stress, trauma, poverty, and lack of care or awareness.
- Many mothers experience stress, anxiety, or postpartum depression.
- Mental health care pre- and post-pregnancy is not always covered the same way as physical health care by insurance.
- Workforce shortages post-pandemic are causing delays in care.
- Connection to substance use, smoking, and weight gain (due to medications).
- Causes: Stigma, insurance issues, provider shortages, medication side effects.

Themes from Interviews related to Children's Health

- Many children in Cuyahoga County are at risk of asthma.
- Early sexual activity, STDs, and a lack of sex education.
- Children are vulnerable to mental health issues, suicide, and stress.
- Limited access to preventive and supportive services.
- Homicide is a leading cause of death among African American men and boys.
- Broader concern about premature death, including child fatalities.

Indicators of concern

In 2022, one in ten newborns in Cuyahoga County (10.8%) had a low birthweight, which is higher than the Ohio rate (8.7%) and nearly all other Ohio counties. (Source: Ohio Department of Health, Vital Statistics)

In 2022, more than a quarter of Cuyahoga children (26.7%) experienced food insecurity,[1] which is substantially higher than the Ohio rate (19.8% of children). (Source: Feeding America)

[1] The U.S. Department of Agriculture (USDA) defines food insecurity as limited or uncertain availability of nutritionally adequate foods or uncertain ability to acquire these foods in socially acceptable ways.

Wellbeing

Themes from Interviews

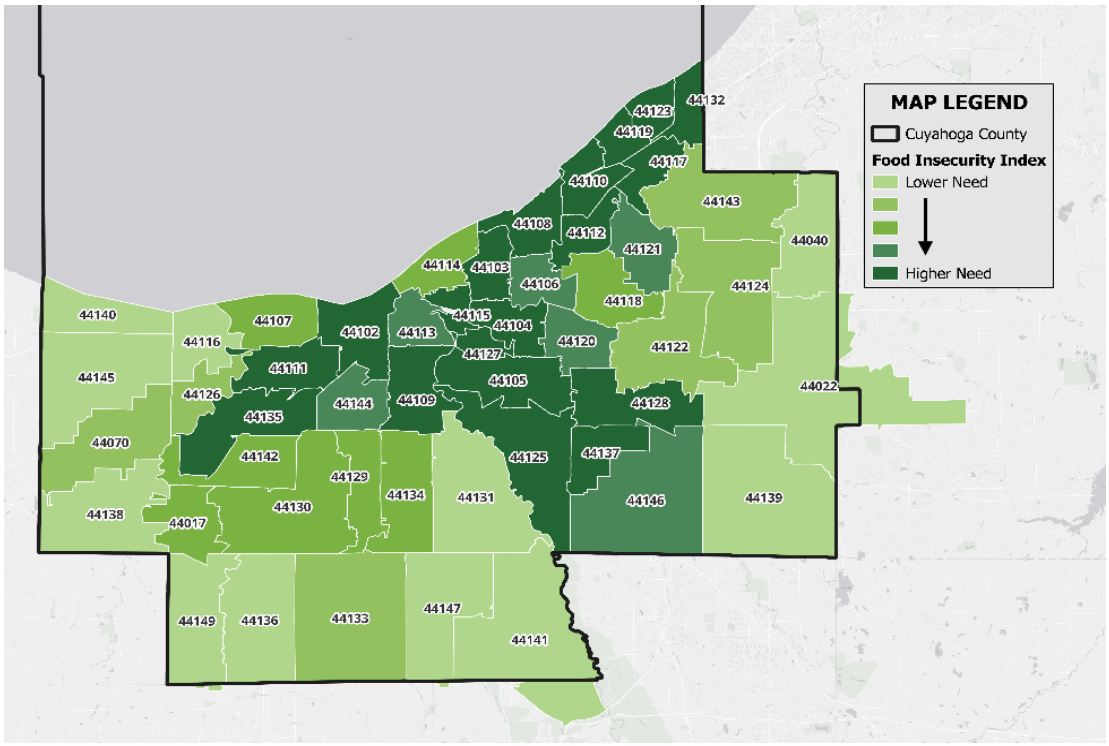
- Low-income populations face barriers to healthcare, nutritious food, and safe environments.
- Obesity rates are high among older adults.
- Causes: Poverty, limited access to affordable and healthy food options and inactive lifestyle.

Indicators of Concern

Food Insecurity Index

- The Food Insecurity Index is a measure of non-medical factors that are correlated with food-related hardship. In Cuyahoga County, the zip code with greatest need is 44104 (Cleveland).
- The Food Insecurity Index is calculated by Conduent Health Communities Institute using data from Claritas Pop-Facts (2024), Claritas Consumer Spending Dynamix (2024), and American Community Survey (2018-2022).

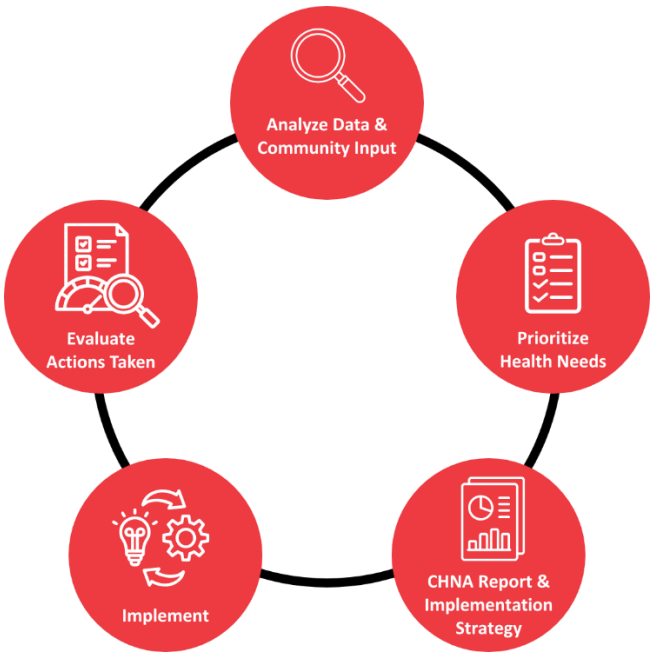
FOOD INSECURITY MAP



Evaluation of Progress Since Prior Report

University Hospitals completes a CHNA every three years to fulfill the Patient Protection and Affordable Care Act (ACA) requirements for tax-exempt hospitals. This assessment process allows hospitals to identify and address the health needs of the communities they serve, ensuring they are meeting the needs of their population and promoting community health. An important piece of this three-year cycle includes the ongoing review of progress made on priority health topics set forth in the preceding CHNA and Implementation Strategy (Figure 2). By reviewing the actions taken to address priority health issues and evaluating the impact those actions have made in the community, it is possible to better target resources and efforts during the next assessment.

FIGURE 2: THE CHNA CYCLE



Priority Health Needs from Preceding CHNA

University Hospitals (UH) priority health areas for years 2023-2025 were:

- Behavioral Health (Mental Health & Drug Use/Misuse)
- Accessible and Affordable Healthcare
- Community Conditions (Access to Healthy Food & Community Safety)

Highlights of Priority Health Needs Progress

The following section includes notable highlights from a few of the initiatives implemented since the last CHNA to address the priority health needs. For a more detailed list of UH initiatives and outcomes see Appendix D.

Priority Health Need: Behavioral Health (Mental Health & Drug Use/Misuse)

Behavioral health emerged as a top concern in CHNA and has remained a cornerstone of University Hospitals community engagement efforts, with a strong focus on education, prevention, and strategic partnerships. The hospital has delivered impactful programming across schools and community settings, using interactive tools like impaired-vision goggles to effectively teach youth about substance misuse and mental health. Efforts have extended to elementary schools and libraries, reinforcing early education around wellness topics such as nutrition and hygiene. Collaborations with organizations like the Lorain County Alcohol and Drug Abuse Services (LCADA), the Far West Center, and Riveon have expanded the hospital's reach, allowing it to provide more comprehensive behavioral health support across both Lorain and Cuyahoga Counties. This work reflects a broad, inclusive approach to community wellness that emphasizes access, innovation, and long-term partnerships.

Priority Health Need: Accessible and Affordable Healthcare

University Hospitals has focused its community health efforts on improving access to care, particularly through early detection and chronic disease prevention. By hosting regular events at its wellness centers, senior centers, and other local community venues, the hospital has provided free health screenings and educational resources to thousands of residents. These efforts go beyond clinical care by incorporating financial assistance information and promoting healthy lifestyle habits, making healthcare more approachable and inclusive. UH has built meaningful connections with the community, helping to reduce barriers to care and foster long-term health outcomes.

Priority Health Need: Community Conditions (Access to Healthy Food & Community Safety)

University Hospitals has prioritized improving community conditions by focusing on health education, safety, and youth engagement through a variety of outreach initiatives. Collaborating with schools, libraries, and municipalities, the hospital has delivered tailored programs such as resource fairs, safety events, and hands-on youth training like the Medical Academy and Stop the Bleed. In response to food insecurity, UH implemented initiatives like summer meal programs and healthy cooking classes, while Community Health Workers helped connect individuals to essential support services. UH's community-centered approach emphasizes adaptability and relevance, ensuring that programming reflects the unique needs of each neighborhood it serves and builds lasting trust within the community.

Demographics of Cuyahoga County

Demographic characteristics such as age, socioeconomic status, and race play an important role in shaping the overall health profile of a community. These characteristics provide valuable insight for effective/intentional health care improvement planning and interventions.

Geography and Data Sources

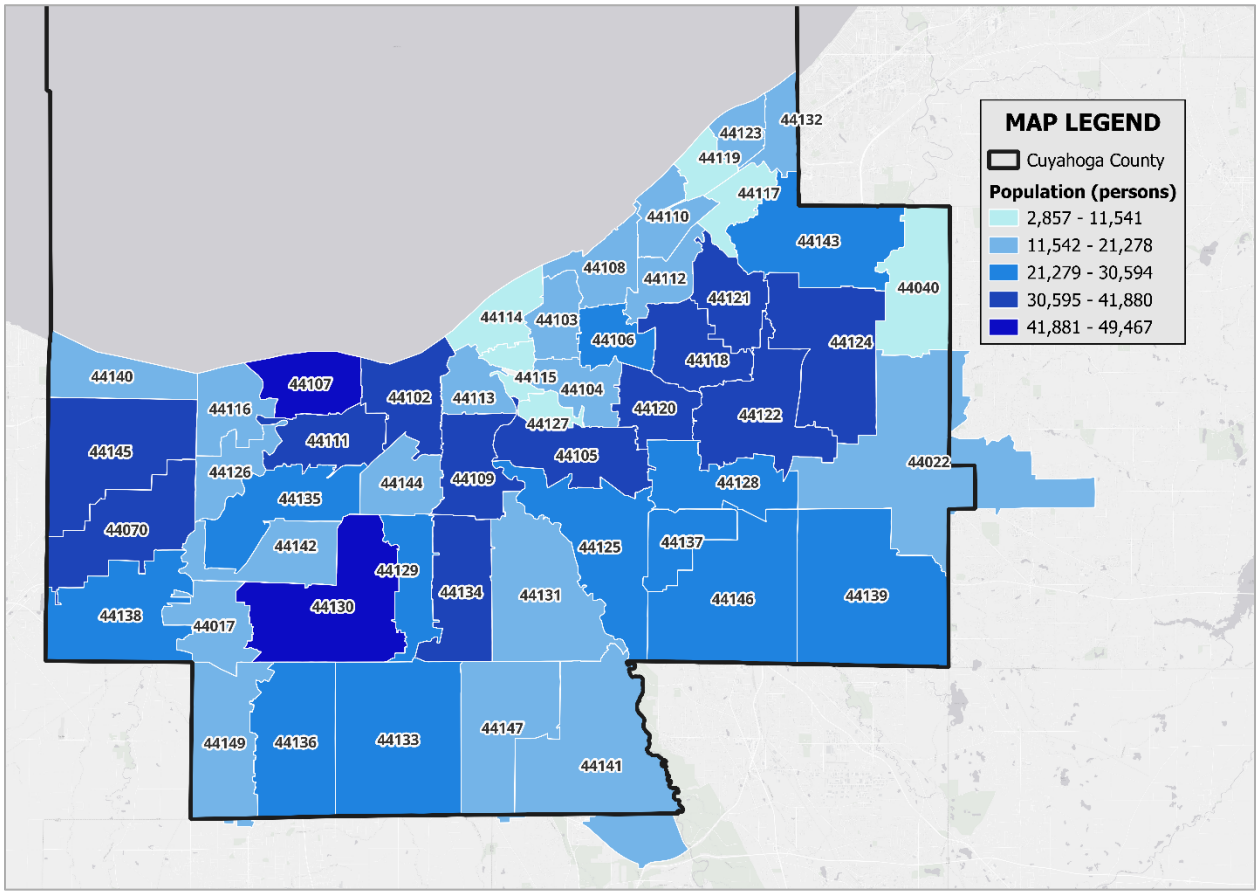
Data are presented in this section at the geographic level of Cuyahoga County. Comparisons to county, state, and national values are also provided when available. Unless otherwise indicated, all demographic estimates at the zip code, county, and state level are sourced from Claritas Pop-Facts (2024 population estimates)[2] and U.S. demographic estimates are sourced from American Community Survey[3] five-year (2019-2023) estimates.

[2] Healthy Northeast Ohio online platform. https://www.healthyneo.org/
[3] American Community Survey. https://www.census.gov/programs-surveys/acs

Population Size

According to 2024 Claritas PopFacts population estimates, Cuyahoga County has an estimated population of 1,228,231 persons. Figure 3 shows the population size in each zip code, with the darkest blue representing the zip codes with the largest populations. Appendix A (p. 93) provides a table of population estimates for each zip code. The two most populated zip codes within Cuyahoga County are 44130 and 44107, with populations of 49,467 and 49,191, respectively.

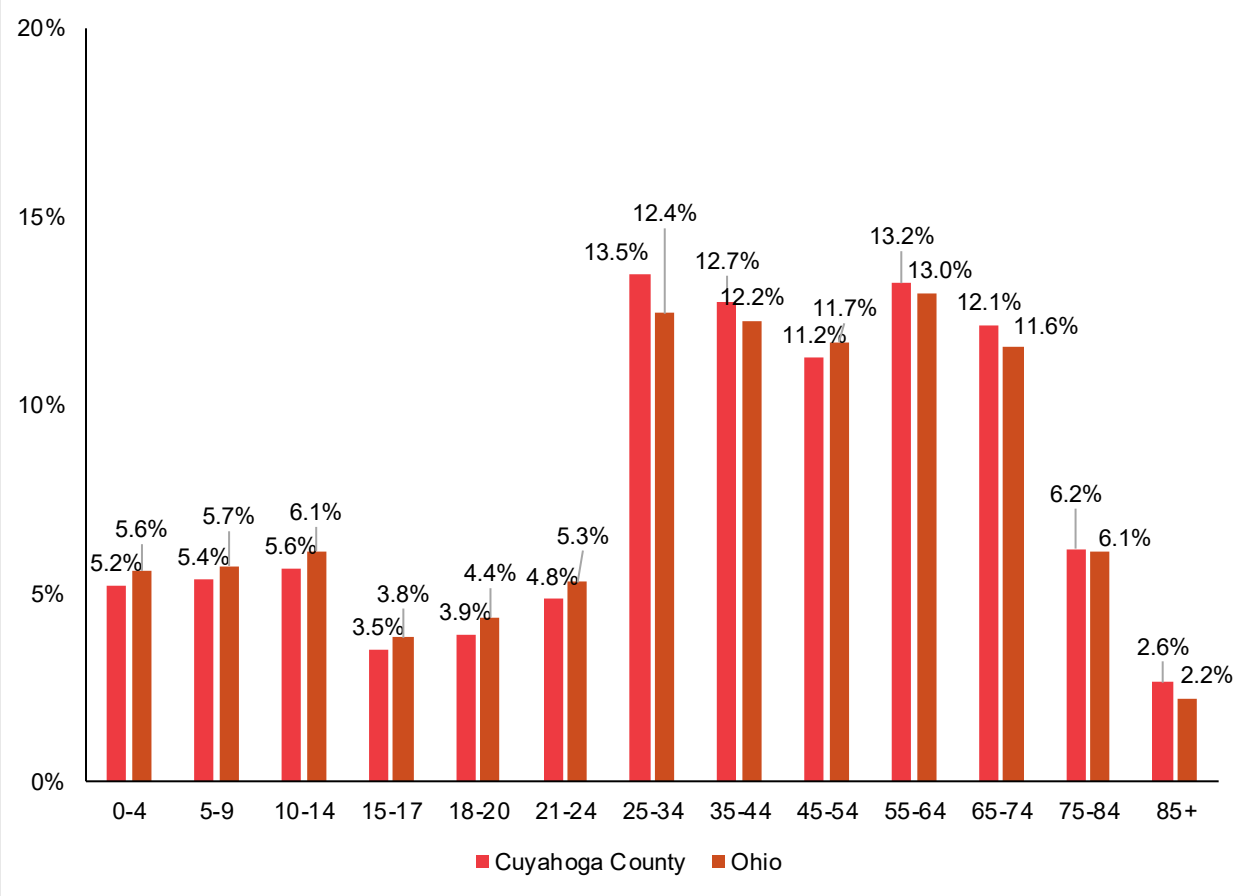
FIGURE 3: CUYAHOGA COUNTY POPULATION BY ZIP CODE



Age

The median age of Cuyahoga County is 41.4 years. As seen in Figure 4, children (ages 0-17) comprised 19.7% of the population, which is somewhat lower than the overall Ohio (21.2%) and the U.S (22.2%) populations. In contrast, Cuyahoga County has a relatively higher percentage of residents age 65 and above (20.9%), compared to both Ohio (19.8%) and the U.S. (16.8%). It is estimated by 2030, close to 30% of residents in Cuyahoga County, over 400,000 people, will be age 60 or over. (HHS Cuyahoga County)

FIGURE 4: POPULATION BY AGE: COUNTY AND STATE COMPARISONS

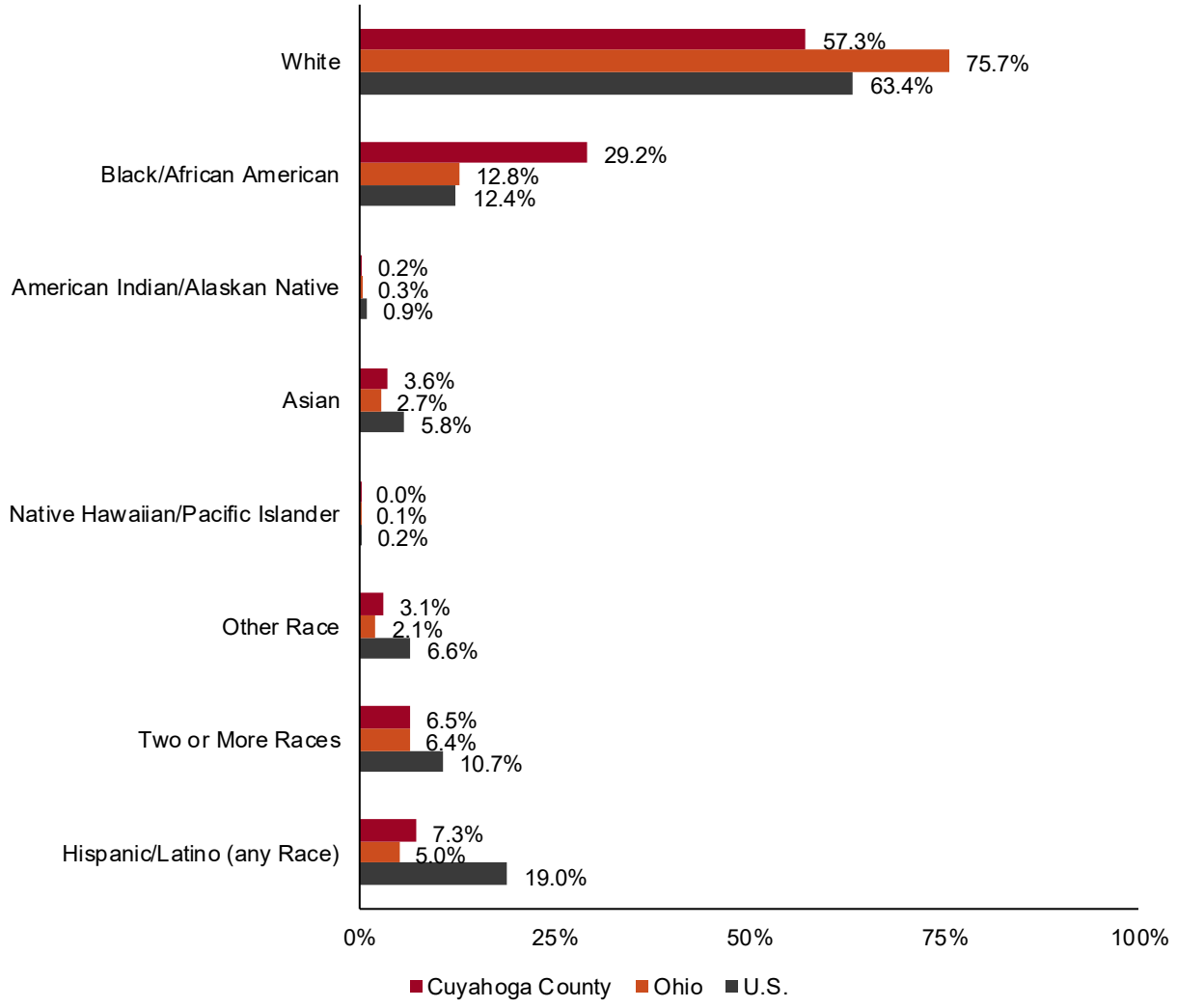


Race and Ethnicity

The racial and ethnic composition of a population is important in planning for future interventions and strategies, particularly for schools, businesses, community centers, healthcare, and childcare. Analysis of health and social determinants of health data by race and ethnicity can also help identify disparities in housing, employment, income, and poverty.

Just over half of the Cuyahoga County population is White (57.3%), and nearly a third is Black or African American. The percentage of Black/African American residents in Cuyahoga is more than twice that of the Ohio and U.S. populations (12.8% and 12.4%, respectively). Compared to Ohio, Cuyahoga also has a higher percentage of Hispanic/Latino residents (7.3% vs. 5.0%) and Asian residents (3.6% vs. 2.7%). See Figure 5 for a more detailed breakdown.

FIGURE 5: POPULATION BY RACE AND ETHNICITY: COUNTY, STATE, AND U.S. COMPARISONS

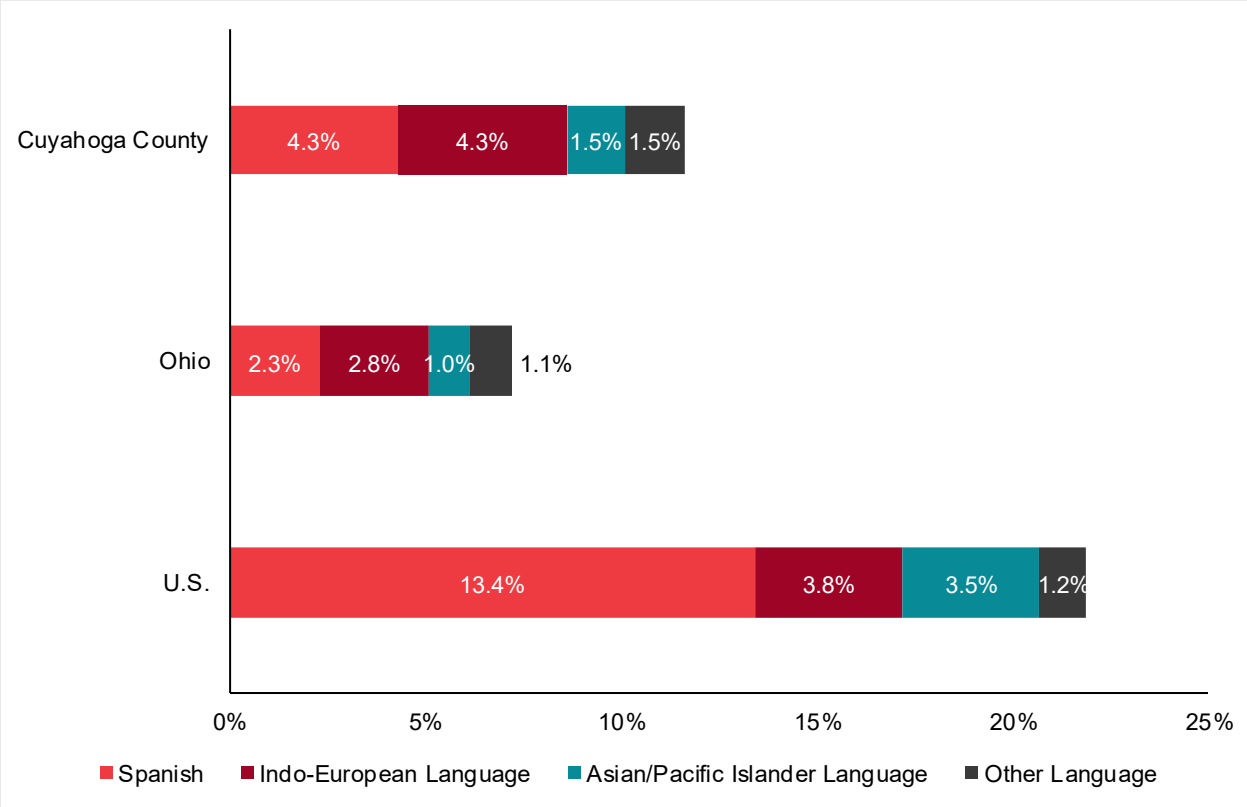


Language and Immigration

Understanding a community's countries of origin and languages spoken at home helps inform the cultural and linguistic context for local health and public health systems.

In Cuyahoga County, 7.6% of residents were born outside the U.S., which is a higher rate than that of Ohio (5.0%).[4] Similarly, Cuyahoga County has a larger percentage of residents who speak a language other than English. More than one in ten county residents age five and above (11.5%) speak a language other than English at home, which is higher than the Ohio rate (7.2%). As seen in Figure 6, 4.3% of Cuyahoga residents speak Spanish at home and 4.3% speak an Indo-European language (e.g., German, Spanish, Polish, Hindi, etc.).

FIGURE 6: POPULATION 5+ BY LANGUAGE SPOKEN AT HOME: COUNTY, STATE, AND U.S. COMPARISONS

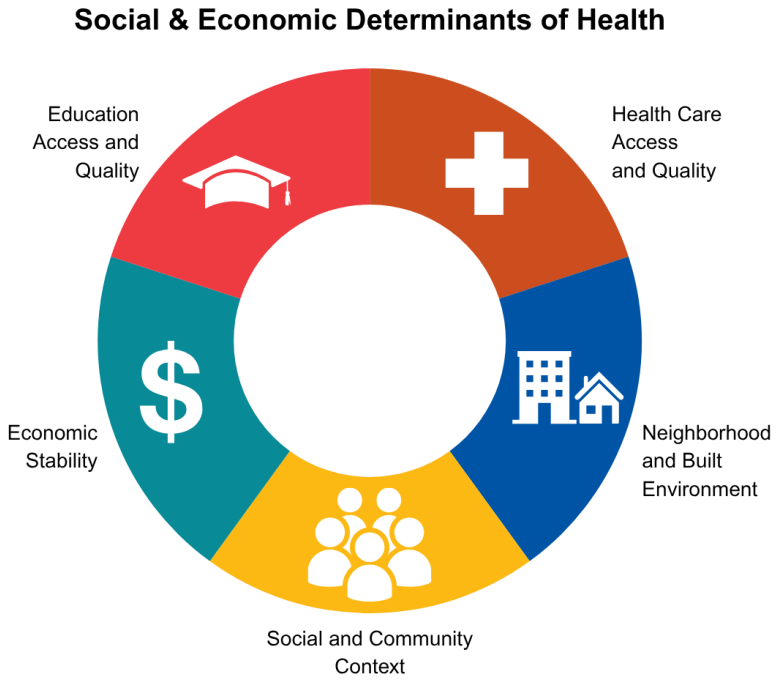


[4] American Community Survey, 2019-2023.

Social Determinants of Health

This section explores the economic, environmental, and social determinants of health impacting residents of Cuyahoga County. Social determinants of health are the everyday conditions in which people live, work, learn, and play that can affect their overall health. Elements like access to safe housing, quality education, employment, transportation, healthy food, and healthcare all influence how healthy a community and its members are or can be. Based on Healthy People 2030 which is a national initiative that sets data-driven objectives to improve the health and well-being of people in the United States over a 10-year period, the social determinants of health (SDOH) can be grouped into five domains. Figure 7 shows the Healthy People 2030 social determinants of health domains.[5]

FIGURE 7: HEALTHY PEOPLE 2030 SOCIAL DETERMINANTS OF HEALTH DOMAINS



[5] Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved [date graphic was accessed], from https://health.gov/healthypeople/objectives-and-data/socialdeterminants-health

Geography and Data Sources

Data in this section are presented at various geographic levels (zip code and/or county) to describe the Cuyahoga County population, depending on data availability. Zip code data may reveal differences in outcomes across the county that would be otherwise masked by county-level data. When available, comparisons to state and/or national values are also provided.

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

Income

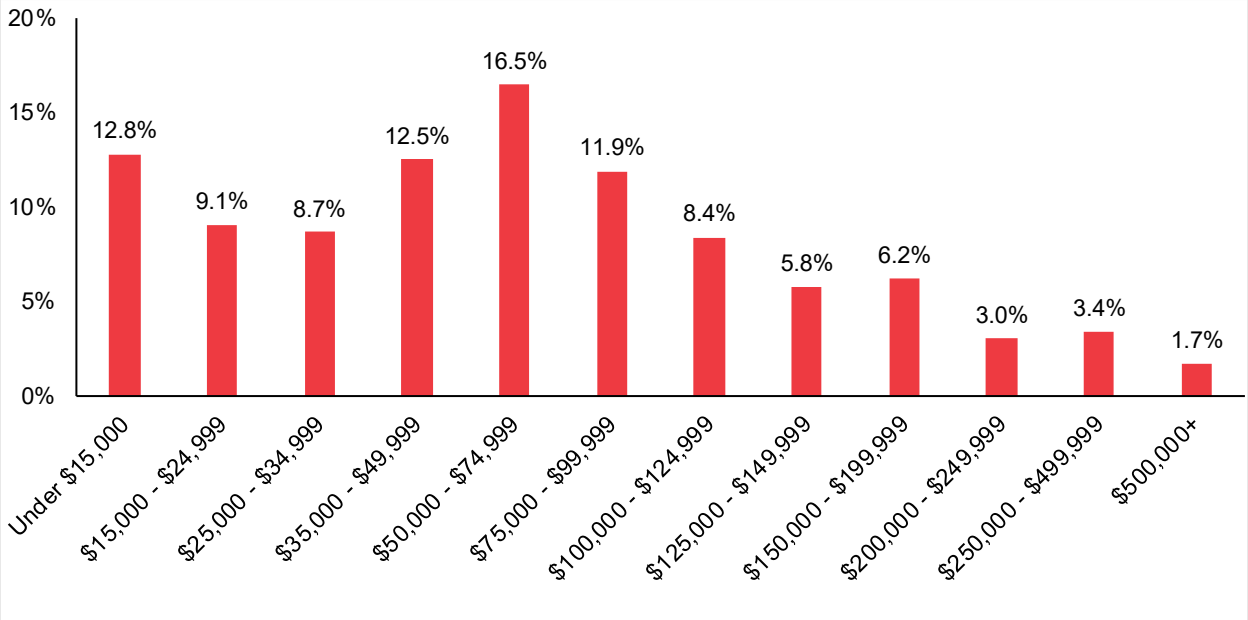
Income is strongly associated with morbidity and mortality, influencing health through myriad clinical, behavioral, social, and environmental factors. For example, a lower income limits one's ability to pay for health care and health insurance, and living in a lower-income neighborhood may limit one's access to secure housing, nutritious foods, and a safe community.[6] Similarly, those with greater wealth are more likely to have a higher life expectancy and reduced risk of a range of health conditions, including heart disease, diabetes, obesity, and stroke.[7]

Figure 8 provides a breakdown of households by income in Cuyahoga County. The income range of $50,000 - $74,999 is shared by the largest proportion of households in Cuyahoga County (16.5%). Households with an income of less than $15,000 make up 12.8% of all households in Cuyahoga County.

[6] U.S. Department of Health and Human Services, Healthy People 2030. https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/poverty

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

FIGURE 8: HOUSEHOLDS BY INCOME, CUYAHOGA COUNTY



The median household income in Cuyahoga County is $60,568. The county median income is lower than the state median income of $68,488, and both are lower than the U.S. median income of $78,538 (see Figure 9).

FIGURE 9: MEDIAN HOUSEHOLD INCOME: COUNTY, STATE, AND U.S. COMPARISONS

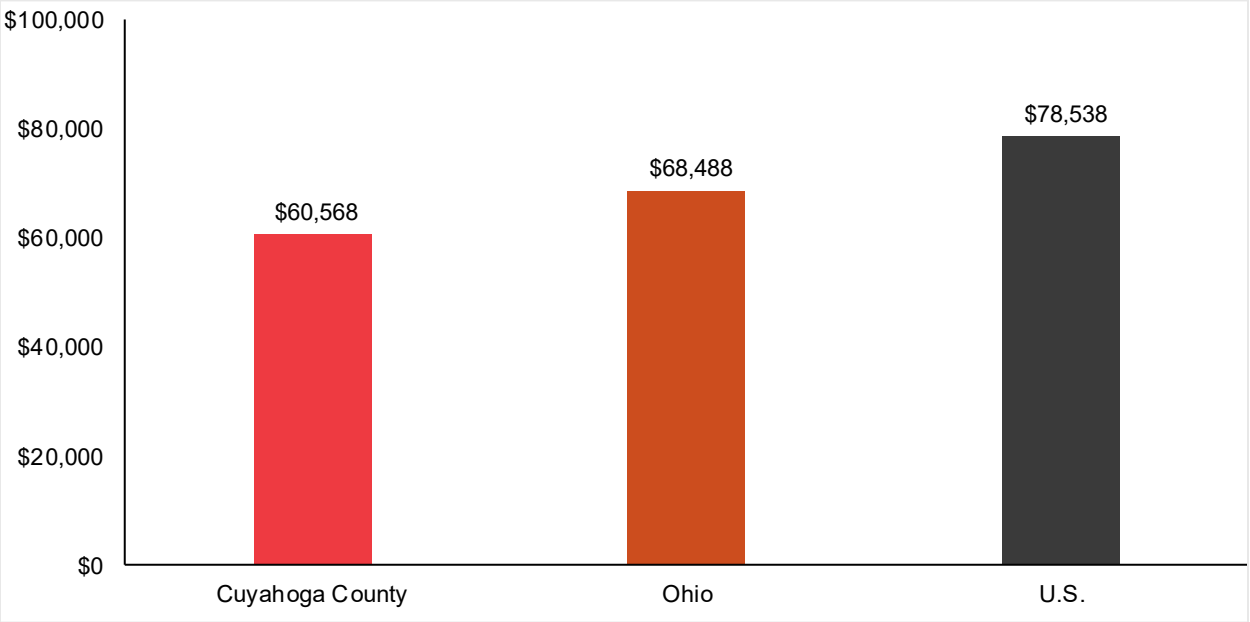
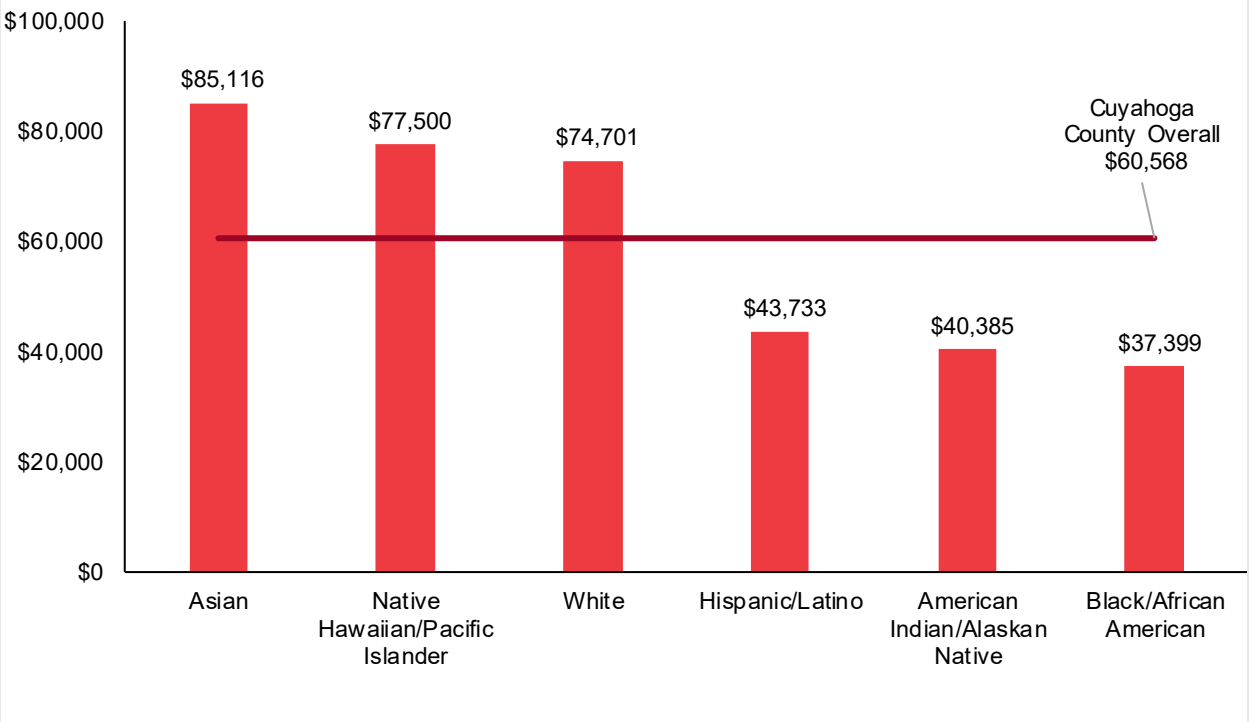


Figure 10 illustrates how the median income in Cuyahoga differs by race and ethnicity. For example, the Black/African American population of Cuyahoga has the lowest median income ($37,399), which is more than $20,000 lower than the population's overall median income ($60,568). The county's Hispanic/Latino and American Indian/Alaskan Native populations also have lower median incomes than the overall population ($43,733 and $40,385, respectively).

FIGURE 10: MEDIAN HOUSEHOLD INCOME BY RACE/ETHNICITY, CUYAHOGA COUNTY

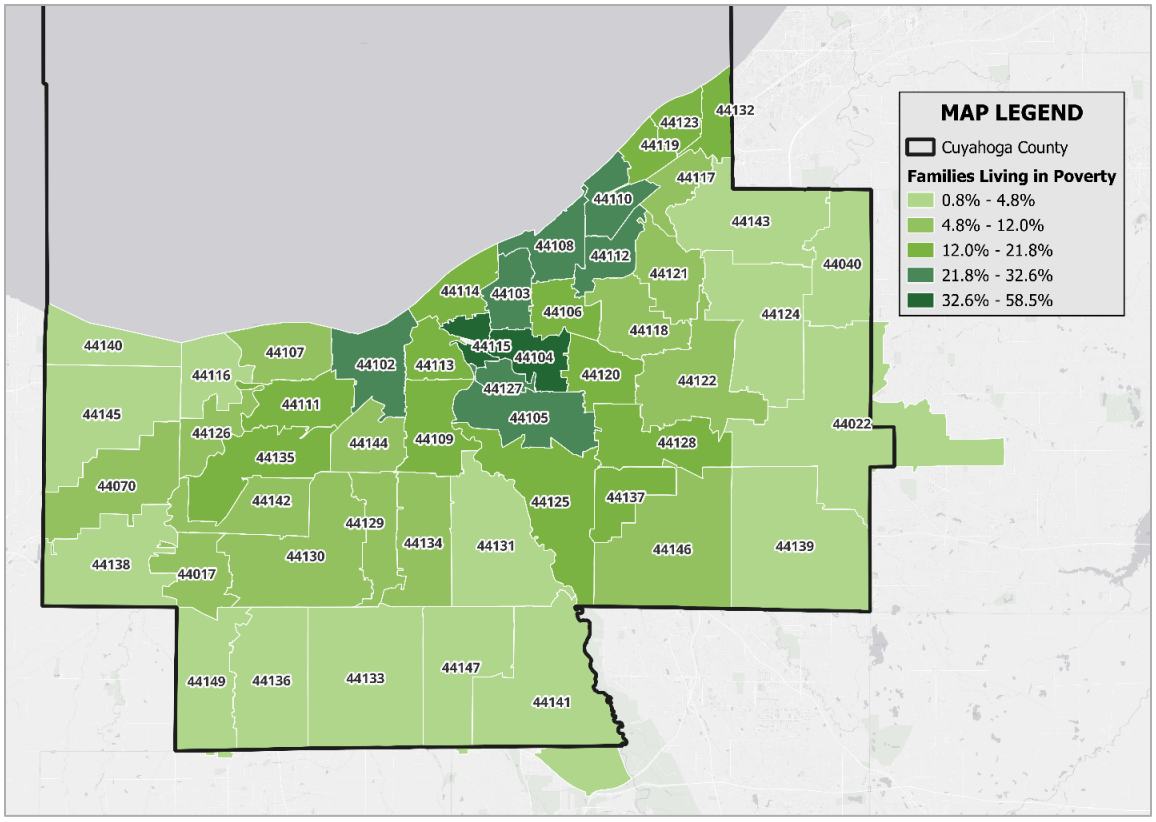


Poverty

Federal poverty thresholds are set every year by the Census Bureau and vary by the number and age of adults and the number of children under age 18 in the family unit. People living in poverty are less likely to have access to healthcare, healthy food, stable housing, and opportunities for physical activity. These disparities mean that people living in poverty are more likely to experience poorer health outcomes and premature death from preventable diseases.[8]

Figure 11 shows the percentage of families living below the federal poverty level by zip code. The darker green colors represent a higher percentage of families living in poverty, with zip codes 44115 and 44104 having the highest percentages at 58.5% and 48.8%, respectively. Overall, 12.2% of families in Cuyahoga County live below the poverty level, which is higher than both the state value of 9.4% and the U.S. of 8.8%. A detailed breakdown for each zip code in Cuyahoga County is provided in Appendix A (p. 93).

FIGURE 11: FAMILIES LIVING BELOW POVERTY LEVEL: CUYAHOGA COUNTY ZIP CODES



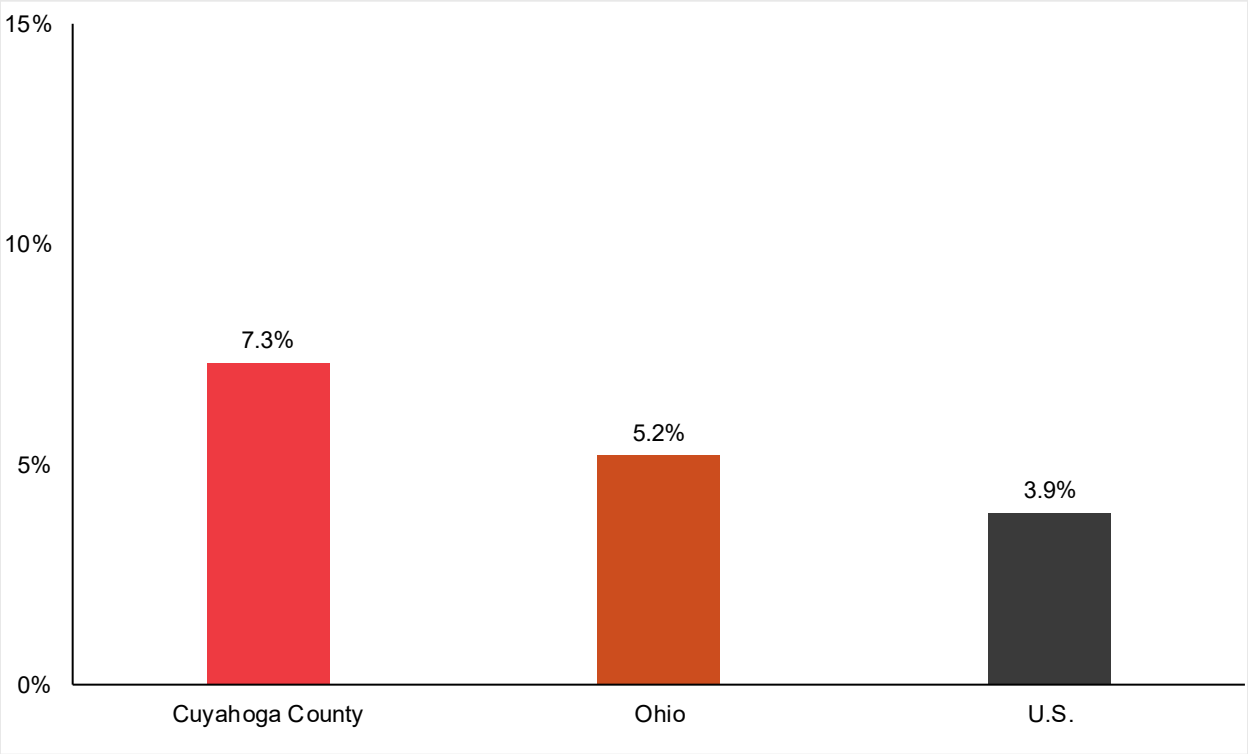
[8] U.S. Department of Health and Human Services, Healthy People 2030. https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/poverty

Employment

A community's employment rate is a key indicator of the local economystatus. An individual's type and level of employment also impacts access to healthcare, work environment, health behaviors and health outcomes. Stable employment can help provide benefits and conditions for maintaining good health. In contrast, poor or unstable work and working conditions are linked to poor physical and mental health outcomes. Work-related stress, injury, and exposure to harmful chemicals are some examples of how certain types of employment can lead to poorer health.[9]

Figure 12 illustrates the county, state, and national unemployment rates. The unemployment rate for Cuyahoga County is 7.3%, which is higher than the Ohio value (5.2%) and nearly twice as high as the U.S. value (3.9%).

FIGURE 12: POPULATION 16+ UNEMPLOYED



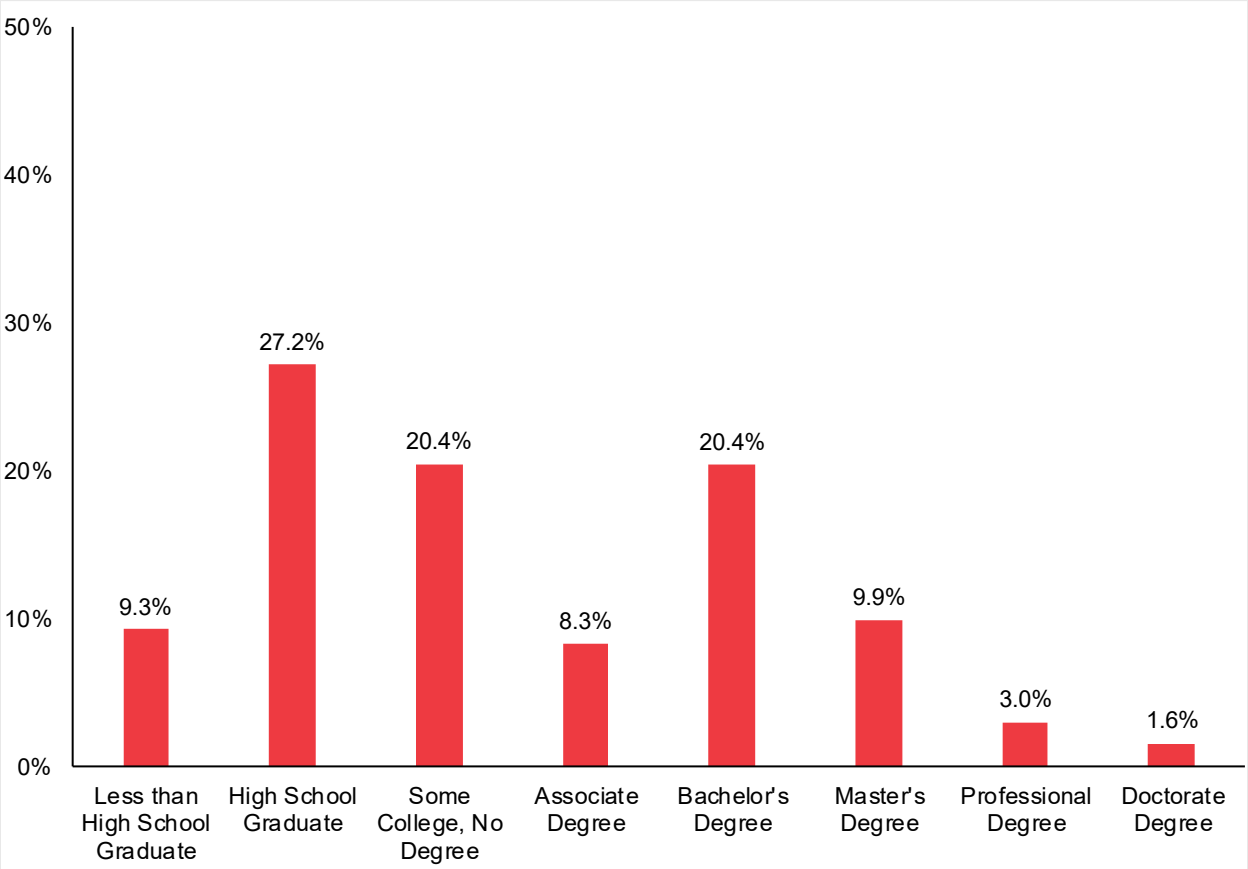
[9] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/socialdeterminants-health/literature-summaries/employment

Education

Education is another important indicator for health and wellbeing. Those with higher levels of education have greater access to well-paying jobs and employer-based health insurance, both of which are linked to greater health care access, safe and stable housing, and other key community resources for well-being. Education can also increase one's knowledge and skills regarding healthy lifestyle behaviors, such as nutritious meal preparation, health literacy, and routine preventative care.[10]

Figure 13 illustrates the highest educational attainment of the Cuyahoga population age 25 and above.

FIGURE 13: POPULATION 25+ BY EDUCATIONAL ATTAINMENT, CUYAHOGA COUNTY

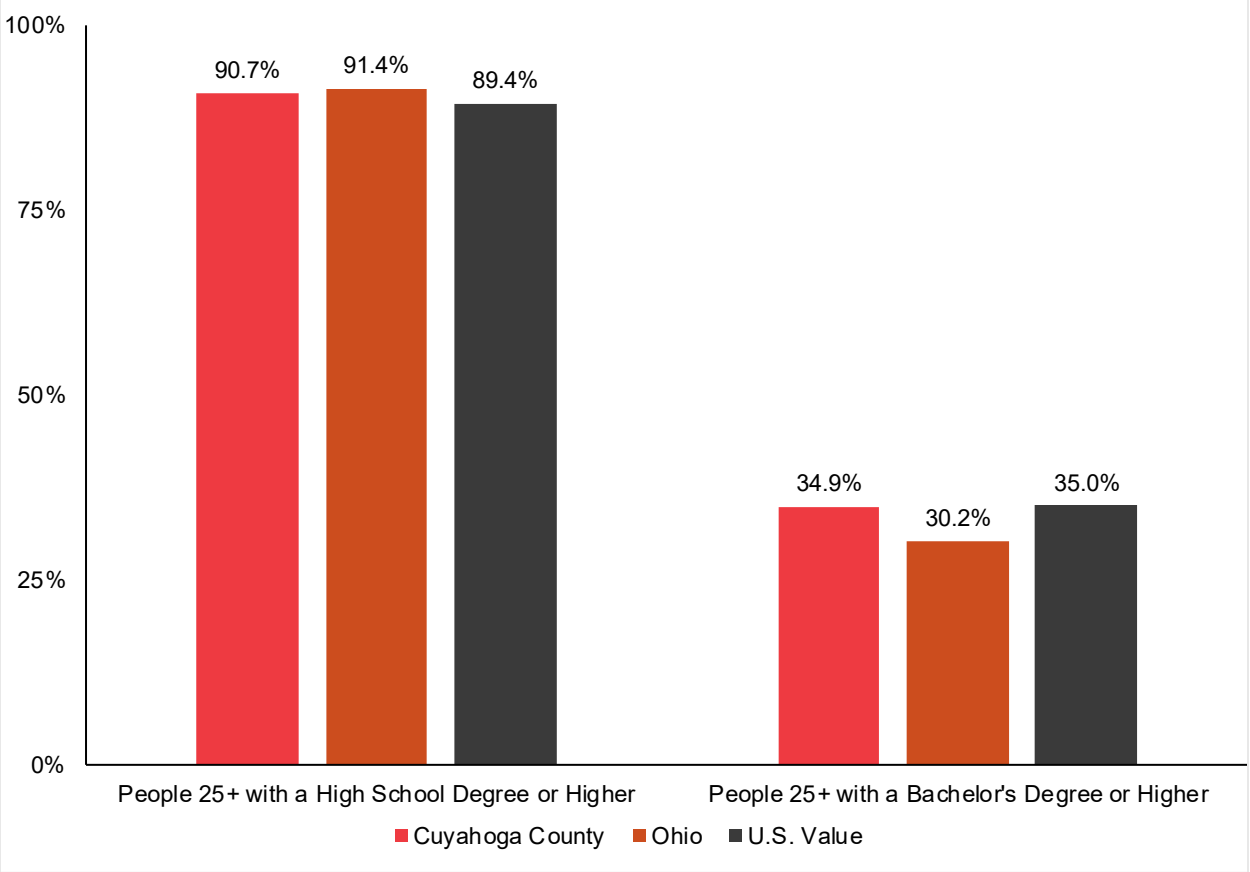


Two important educational milestones are high school completion and completing a Bachelor's degree. The vast majority of the county population (90.7%) have a high school diploma or higher, and more than a third (34.9%) have a bachelor's degree or

[10] Robert Wood Johnson Foundation, Why Education Matters to Health. https://www.rwjf.org/en/insights/our-research/2014/04/why-education-matters-to-health.html

higher. As seen in Figure14, Cuyahoga residents are more likely than the overall population of Ohio to have a Bachelor's degree or higher (34.9% vs. 30.2%).

FIGURE 14: POPULATION 25+ BY EDUCATIONAL ATTAINMENT: COUNTY, STATE, AND U.S. COMPARISONS

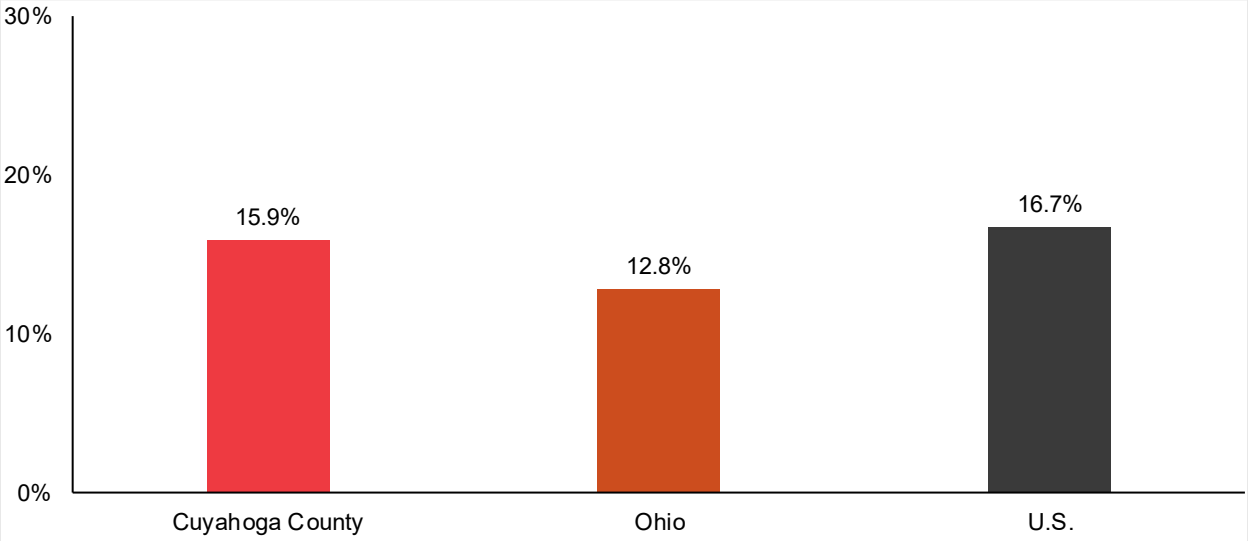


Housing

Safe, stable, and affordable housing provides a critical foundation for health and wellbeing. Severe housing problems, which include housing with either overcrowding, high housing costs, lack of kitchen facilities, or lack of plumbing facilities, can cause significant damage to an individual's or family's health. For example, these problems can contribute to infectious disease risk from poor sanitary conditions. Poor housing conditions may also be a barrier to nutritious home-cooked meals, can raise one's risk for unintentional injury at home, and can even increase one's risk of chronic disease through exposure to hazards such as mold growth and lead paint.[11]

As seen in Figure 15, 15.9% of households in Cuyahoga County have severe housing problems. Households in Cuyahoga are more likely to have these problems than households across Ohio, broadly (12.8%).

FIGURE 15: HOUSES WITH SEVERE HOUSING PROBLEMS: COUNTY, STATE, AND U.S. COMPARISONS



Source: County Health Rankings (2016-2020)

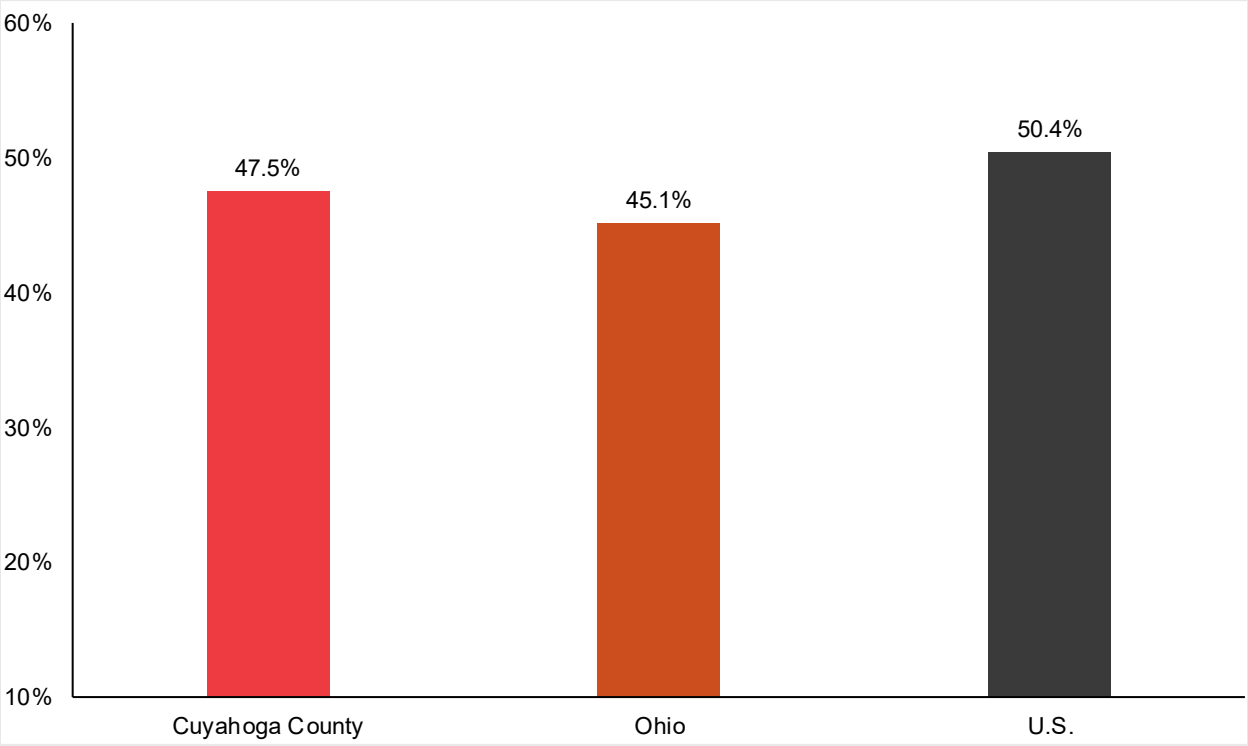
When families must spend a large portion of their income on housing, they may not have enough money to pay for things like healthy foods or healthcare. This is linked to increased stress, mental health problems, and an increased risk of disease.[12]

Although there are many factors which contribute to individuals' household budgets, a common target which has been adopted by Healthy People 2030 to reduce the financial

[11] County Health Rankings, Severe Housing Problems. https://www.countyhealthrankings.org/health-data/community-conditions/physical-environment/housing-and-transportation/severe-housing-problems?
[12] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/browseobjectives/housing-and-homes/reduce-proportion-families-spend-more-30-percent-income-housing-sdoh-04

burden of housing is to spend 30% or less of one's household income on housing.[13] As seen in Figure 16, nearly half of renters in Cuyahoga County (47.5%) spend 30% or more of their income on rent. This rate is somewhat higher than the Ohio population, and somewhat lower than the overall U.S. population.

FIGURE 16: RENTERS SPENDING 30% OR MORE OF HOUSEHOLD INCOME ON RENT



Source for all estimates: American Community Survey (2019-2023)

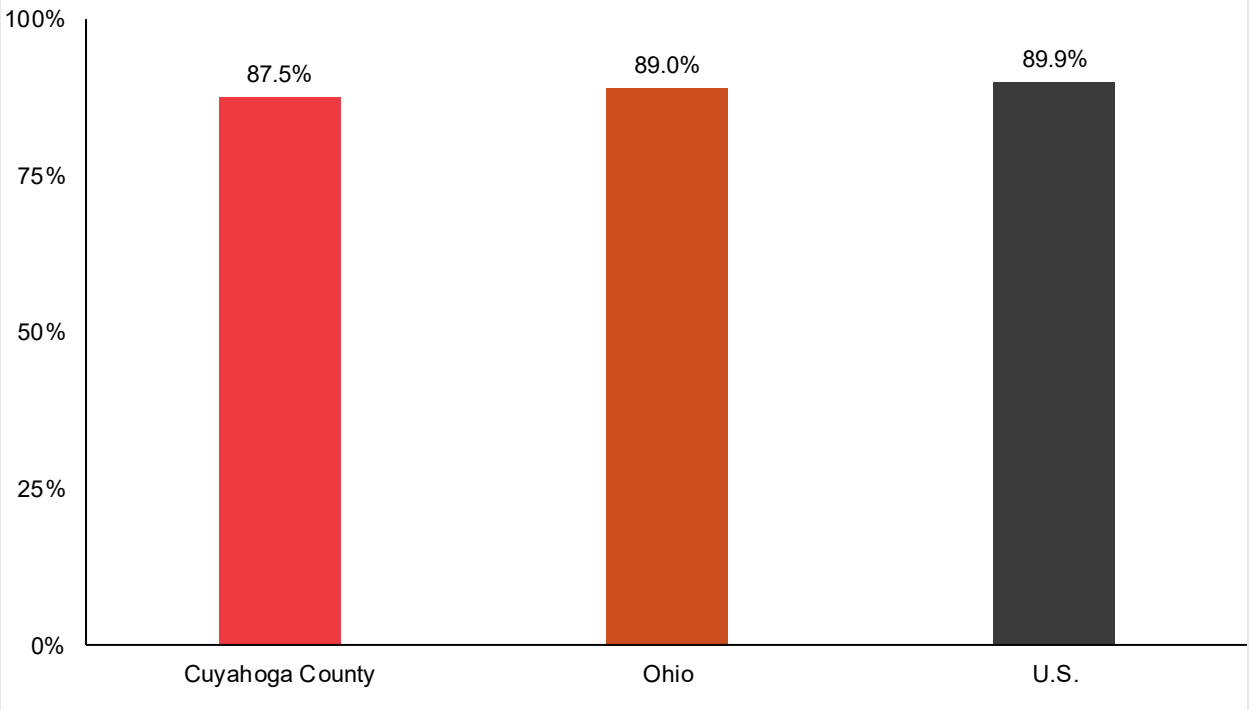
[13] U.S. Department of Health and Human Services, Healthy People 2030. https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/housing-and-homes/reduce-proportion-families-spend-more-30-percent-income-housing-sdoh-04

Neighborhood and Built Environment

Reliable internet service is no longer a luxury—it's a critical tool for accessing timely and effective healthcare. It empowers patients to become involved partners in their care. Individuals can schedule appointments, access test results, and communicate with providers to help manage their chronic conditions. Telemedicine, which became essential during the COVID-19 pandemic, depends entirely on stable internet, allowing patients, especially those in underserved areas, to receive care from their homes. Without reliable/stable internet, there may be delays in health care, missed follow-up appointments, or a disconnection from other health resources. Additionally, this digital divide can lead to adverse health outcomes and widen existing health disparities.[14]

Figure 17 shows the percentage of households with an internet subscription. Most people across the county (87.5%) have internet access at home, although this rate is somewhat lower than that of Ohio and the nation.

FIGURE 17: HOUSEHOLDS WITH AN INTERNET SUBSCRIPTION: COUNTY, STATE, AND U.S. COMPARISONS



Source for all estimates: American Community Survey (2019-2023)

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

Data Collection Methodology and Key Findings

Two types of data were analyzed for this CHNA: primary and secondary data. Each type of data was analyzed using a unique methodology. Findings were organized by health topics. These findings were then compiled to form a comprehensive overview of the community health needs within the UH service area.

Primary Data Collection and Analysis

Primary data used in this assessment consisted of a key informant interview (KIIs) with community stakeholders. These findings expanded upon information gathered from the secondary data analysis to inform this UH CHNA.

Key Informant Methodology:

HCI conducted key informant interviews via phone. Interviewees invited to participate were recognized as having expertise in public health, special knowledge of community health needs, representing the broad interests of the community served by the hospital, and/or being able to speak to the needs of medically underserved or vulnerable populations. Nineteen individuals agreed to participate as key informants. Table 1 lists the represented organizations that participated in the interviews.

TABLE 1. KEY INFORMANT INTERVIEWS

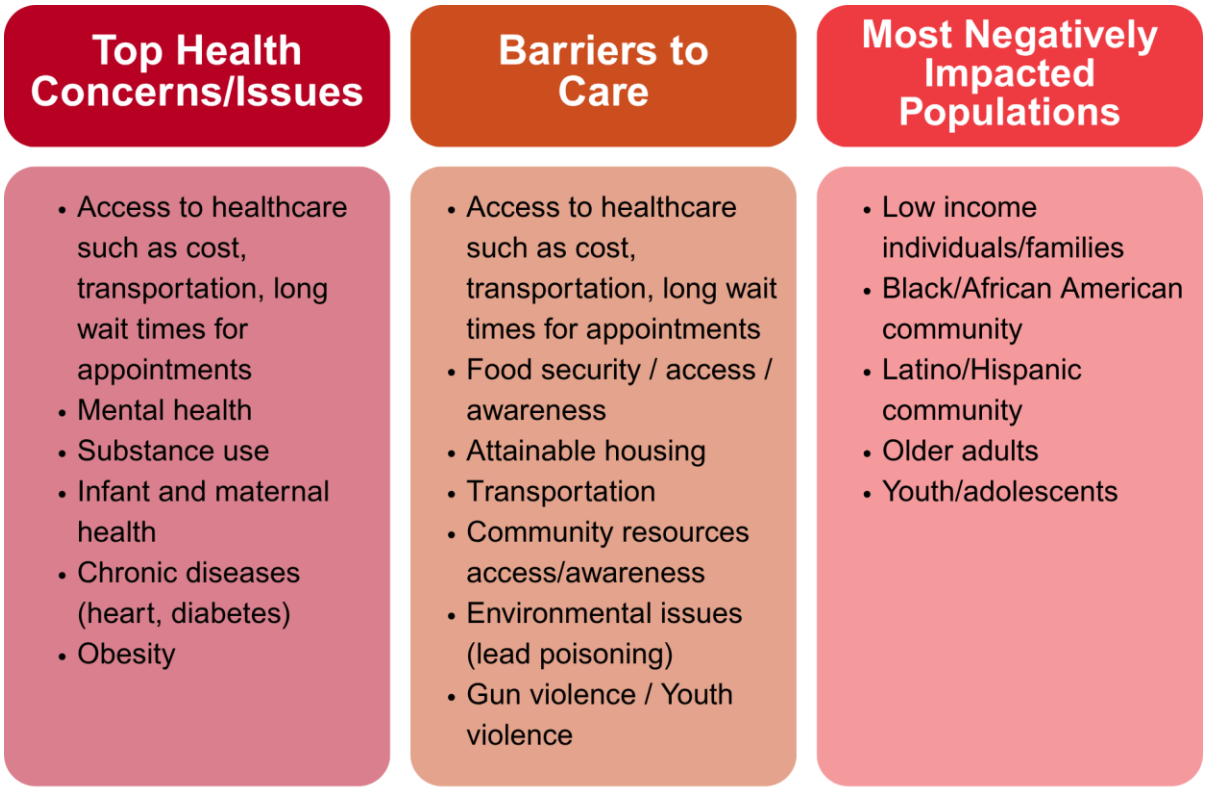
Key Informant Organizations	
Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Board of Cuyahoga County	Greater Cleveland Food Bank
ASIA (Asian Services In Action)	Lead Safe Cleveland Coalition
Benjamin Rose Institute on Aging	LGBT Community Center of Greater Cleveland
Birthing Beautiful Communities	National Alliance on Mental Illness (NAMI) Greater Cleveland
Boys and Girls Club of Northeast Ohio	Neighborhood Family Practice (FQHC)
City of Cleveland Department of Public Health	Positive Education Program (PEP)
Cuyahoga County Board of Health	Project Noir
Cuyahoga Metropolitan Housing Authority	ThirdSpace Action Lab
Esperanza	Towards Employment
First Year Cleveland	

The nineteen key informant interviews took place between February and May 2025. The questions focused on the interviewee's background and organization, largest perceived health needs and barriers of concern in the community, and the impact of health issues on the populations they serve and other vulnerable populations. Interviewees were also asked about their knowledge around health topics where there were data gaps in the secondary data. A list of the questions asked in the key informant interviews can be found in Appendix B.

Key Informant Analysis Results:

Notes captured from the key informant interviews were uploaded to the web-based qualitative data analysis tool, Qualtrics. Text was coded and organized by themes and analyzed for significant observations. Figure 18 summarizes the main themes and topics that emerged from these discussions.

FIGURE 18: KEY THEMES FORM QUALITATIVE DATA ANALYSIS



Key informants highlight barriers to healthcare access, social determinants and the need for authentic community engagement. The feedback comments highlight several key topics related to healthcare and community well-being in the region. People discuss significant barriers to accessing healthcare services, including lack of convenience, long wait times, and affordability issues. Social determinants of health, such as income,

access to healthy food, and social isolation, are seen as major contributors to poor health outcomes, especially for vulnerable populations. Mental health and substance use challenges are also raised as pressing concerns, with a need for parity in coverage and access to behavioral health services. Across these topics, people emphasize the importance of collaboration and coordination among healthcare providers, community organizations, and other stakeholders to address gaps in services. People also highlight the value of authentic community engagement and empowerment, where healthcare institutions genuinely seek input from residents and demonstrate how that feedback is being used to drive change. Overall, the comments reflect a desire for a more holistic, community-centered approach to improving health and well-being in Cuyahoga County.

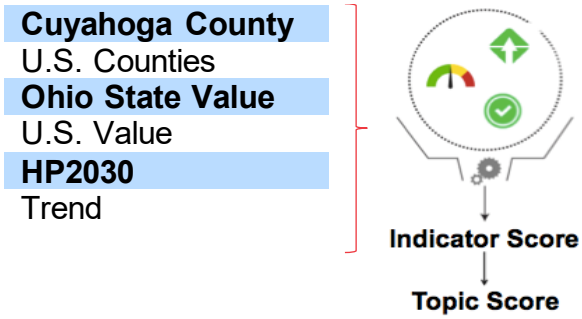
Secondary Data Collection and Analysis

Secondary data used for this assessment were collected and analyzed from the Healthy Northeast Ohio (NEO) community data platform. Healthy NEO is a publicly available website which houses neutral population health data and community health resources to support community health improvement efforts across a 9-county region.

The data on this platform, maintained by researchers and analysts at Conduent HCI, includes over 400 community indicators, spanning at least 24 topics in the areas of health, social determinants of health, and quality of life. The data are primarily derived from state and national public secondary data sources. The value for each of these indicators is compared to other communities, national targets, and to previous time periods.

HCI's Data Scoring Tool systematically summarizes multiple comparisons and ranks indicators based on highest need. For each indicator, the Cuyahoga County value was compared to a distribution of Ohio and U.S. counties, state and national values, Healthy People 2030 targets, and significant trends, as shown in Figure 19.

FIGURE 19: SECONDARY DATA SCORING METHODOLOGY



Each indicator was then given a score based on the available comparisons. These scores range from 0 to 3, where 0 indicates the best outcome and 3 indicates the poorest outcome. Availability of each type of comparison varies by indicator and is dependent upon the data source, comparability with data collected from other communities, and changes in methodology over time. These indicators were then grouped into community health need topic areas and each topic area with at least three indicators was given an average topic score, based on those indicators' scores.

Due to the limited availability of zip code, census tract, or other sub-county health data, the data scoring technique is only available at the county level. The data scoring results are therefore presented in the context of Cuyahoga County.

Table 2 shows the Health and Quality of Life topic scoring results for Cuyahoga County.

TABLE 2: TOPIC SCORING RESULTS

Health and Quality of Life Topics	Score
Other Chronic Conditions	1.92
Sexually Transmitted Infections	1.89
Economy	1.82
Education	1.72
Prevention & Safety	1.72
Older Adults	1.67
Children's Health	1.65
Wellness & Lifestyle	1.64
Alcohol & Drug Use	1.57
Community	1.57
Maternal, Fetal & Infant Health	1.51

The highest scoring and, therefore, most concerning topic area was “Other Chronic Conditions” (which includes chronic health conditions such as Kidney Disease, Osteoporosis, and Arthritis) with a score of 1.92. Topics that received a score of 1.50 or higher were considered a significant health need. Eleven topics scored at or above this threshold. Topic areas with fewer than three indicators could not be scored and, thus, were considered a data gap. Please see Appendix A (p. 93) for the full list of Health and Quality of Life topics, including the list of national and state indicators that are categorized into and included in the secondary data analysis for each topic area. Further details on the quantitative data scoring methodology are also available in Appendix A (p. 93).

Maps in this report were generated using Electronic Health Record (EHR) data sourced from University Hospitals, which have been weighted to more accurately reflect the broader population's demographic composition as reported in census data. We applied a proportional stratification adjustment—a statistical weighting method that aligns EHR patient records by gender, race, and age group with their corresponding proportions in the census. This ensures that our visualizations and analyses are demographically representative and reduces potential bias stemming from uneven data representation.

Data Considerations

Several limitations of the data should be considered when reviewing the findings presented in this report. Although the topics by which data are organized cover a wide range of health and health-related areas, within each topic there is a varying scope and depth of secondary data indicators and primary data findings.

Regarding the secondary data, some health topic areas have a robust set of indicators, but for others there may be a limited number of indicators for which data is available.

For the primary data, the breadth of findings is dependent upon who was selected to be a key informant.

For all data, efforts were made to include a wide range of secondary data indicators and community member expertise areas.

Identification of Significant Health Need

Findings from both primary and secondary data sources were analyzed and combined to identify the significant health needs of the Cuyahoga County community.

Health needs were determined to be significant if they met certain criteria in at least one of the two data sources: a secondary data score of 1.50 or higher, and frequency by which the topic was discussed within/across interviews. Figure 20 summarizes the process for identifying significant health needs.

FIGURE 20: PROCESS FOR IDENTIFYING SIGNIFICANT HEALTH NEEDS

Data Synthesis

Primary and secondary data were collected, analyzed, and synthesized to identify the significant community health needs in Cuyahoga County.

The significant health needs identified from data sources were analyzed based on the areas of data overlap. Primary data from key informant interviews as well as secondary data findings identified ten areas of significant need. Table 3 outlines the ten significant health needs (in alphabetical order) alongside the corresponding data sets that identified the need as significant.

TABLE 3: HEALTH TOPICS SHOWING OVERLAPPING EVIDENCE OF NEED

Health Topic (alphabetical order)	Community Input	Secondary Data
Cancer		✓
Chronic Diseases (Diabetes, Heart Disease, Other Conditions,)	✓	✓
Children's Health	✓	✓
Health Care Access & Quality	✓	
Maternal, Fetal and Infant Health	✓	✓
Mental Health & Mental Disorders	✓	
Older Adults	✓	✓
Substance Use	✓	✓
Sexually Transmitted Infections	✓	✓
Wellness and Lifestyle	✓	✓

** Definitions of health topics and related secondary data indicators are included in the Appendix A*

Significant Health Needs Identified for Cuyahoga County

Based on the criteria and overlapping evidence of need shown, ten needs emerged as significant. For prioritization session, Other Conditions health topic was included under Chronic Diseases. Table 4 illustrates the ten significant health needs, listed in alphabetical order, that were included for prioritization based on the findings of all forms of data collected for University Hospitals 2025 CHNA.

TABLE 4: CUYAHOGA COUNTY SIGNIFICANT HEALTH NEEDS

Health Topic (alphabetical order)
Cancer
Chronic Diseases (Diabetes, Heart Disease, Other Conditions)
Children's Health
Health Care Access & Quality
Maternal, Fetal and Infant health
Mental Health & Mental Disorders
Older adults
Substance Use
Sexually Transmitted Infections
Wellness and Lifestyle

Prioritization of Significant Health Needs

To better target activities to address the most pressing health needs in the community, University Hospitals (UH) convened a group of UH community outreach caregivers who serve patients and community members in Cuyahoga County to participate in a presentation of data on significant health needs facilitated by Conduent HCI. Following the presentation, participants were given access to an online link to complete an exercise ranking the significant health needs based on a given set of criteria.

UH CHNA Steering Committee reviewed the scoring results of the significant community needs and determined prioritized health needs based on the same set of criteria used in the scoring exercise.

Process

An open invitation to participate in the UH CHNA data synthesis presentation and virtual prioritization ranking activity was extended across hospitals in the weeks preceding the meetings held on June 5, 2025. A total of 21 individuals representing the UH hospital system registered for the event, of these, 12 submitted feedback to the online prioritization ranking activity.

During the virtual prioritization meeting, the group reviewed and discussed the results of primary and secondary data analyses leading to significant health needs. After the data synthesis presentation, participants were given access to an online scoring tool and an opportunity to score each of the significant health needs by how well they met the criteria set forth by UH.

The criteria for prioritization included:

Scope and Severity: gauged the magnitude of each health issue

Ability to Impact: the perceived likelihood of positive impact on each health issue

The group also agreed that root causes, disparities, and social determinants of health would be considered for all prioritized health topics resulting from prioritization.

Participants scored each health area against each criterion on a scale from 1-3 with 1 meaning it did not meet the given criterion, 2 meaning it met the criterion, and 3 meaning it strongly met the criterion. In addition to considering the data presented by Conduent HCI in the presentation, participants were encouraged to use their own

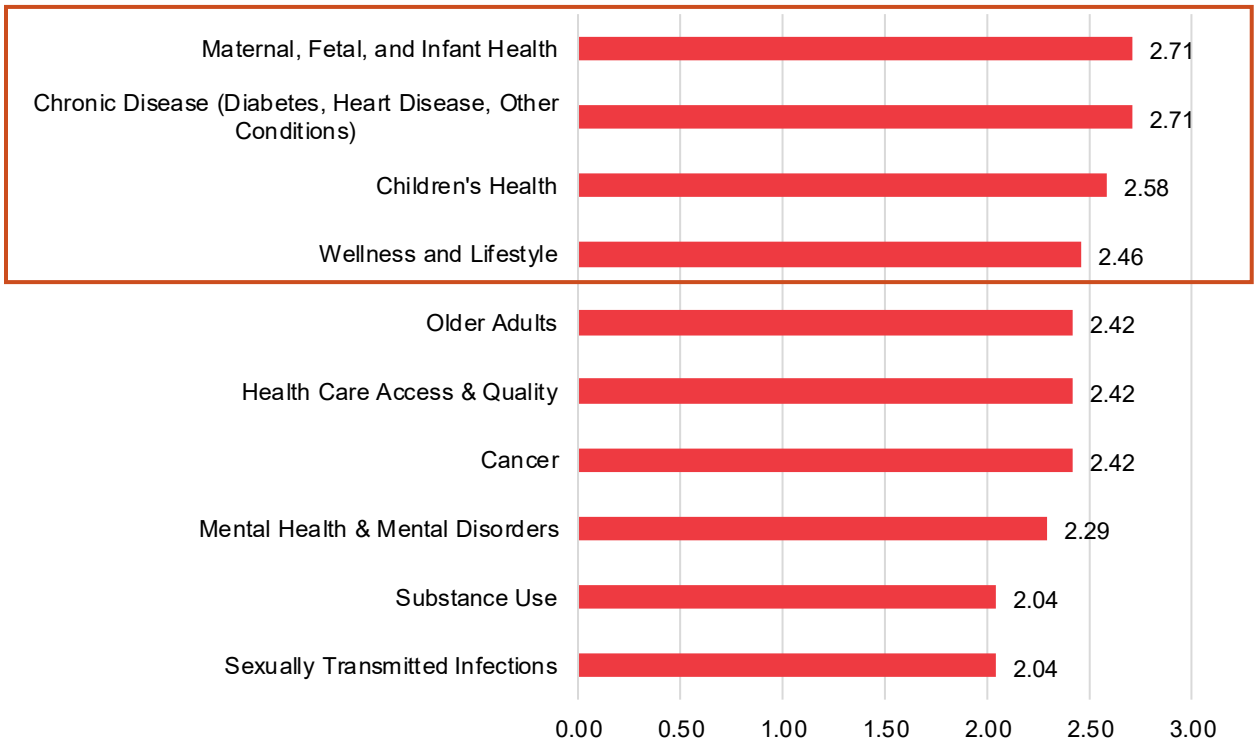
judgment and knowledge of the community in considering how well a health topic met the criteria.

Completion of the online exercise resulted in a numerical score for each health need that correlated with how well that particular need met the criteria for prioritization. Conduent HCI downloaded the online results, calculated the scores, and then ranked the significant health needs according to their topic scores, with the highest scoring health need receiving the highest priority ranking.

Prioritized Health Needs

UH CHNA Steering Committee reviewed the scoring results of the significant community needs and determined prioritized health needs based on the same set of criteria used in the scoring exercise and considering the threshold of 1.50 and above. The overall prioritization ranking can be seen in Figure 21 below.

FIGURE 21: OVERALL PRIORITIZATION RANKING



The three priority health areas that will be considered for subsequent implementation planning are:

Priority Area 1: Chronic Disease

Priority Area 2: Maternal and Child Health

Priority Area 3: Wellbeing

For the implementation strategy, UH decided to combine Maternal, Fetal, and Infant Health with Children's Health under a single health topic titled Maternal and Child Health. Additionally, the topic Wellness & Lifestyle was renamed to Wellbeing to align with UH's overall Community Health Investment Strategy.

Additionally, Older Adults has been identified as a priority population and will be a key focus area for UH Seidman Cancer Center as it relates to Cancer.

A deeper dive into the primary data and secondary data indicators for each of these three priority health topic areas is provided later in the next section of the report. This information highlights how each issue became a high priority health need for Cuyahoga County. UH hospitals plan to build upon these efforts and continue to address these health needs in their upcoming Implementation Strategy. While other identified health needs were not collectively prioritized, UH remains committed to supporting efforts to address them where possible.

Prioritized Health Needs

The following section dives deeper into each of the prioritized health needs to understand how findings from primary and secondary data led to the health topic becoming a priority health issue for Cuyahoga County. The three prioritized health needs are presented in alphabetical order.

Each prioritized health topic includes key themes from primary data and secondary data warning indicators. The warning indicators shown for certain health topics are above the 2 thresholds for Cuyahoga County and indicate areas of concern. See the legend below for how to interpret the distribution gauges and trend icons used within the data scoring results tables.

The compare to distribution gauge measures how your community is doing compared to other communities in your state, the U.S. or region.	
	This gauge indicates the location is in the best 50% of all the similar location.
	This gauge indicates the community value is in the 50th to 25th percentile of all the similar locations.
	Indicates the community value is in the worst percentile of all the similar location.
The square represents a comparison to a trend over time. The trend looks at how the indicator is doing over multiple time periods.	
	This square shows that the indicator is trending up, with significant change over time, and this is not the ideal direction.
	The indicator is trending down with non-significant change over time , and this is not the ideal direction.
	The indicator is trending down, with significant change over time, and this is the ideal direction.
	The indicator is trending down with non-significant change over time , and this is the ideal direction.
	The indicator is trending up, with significant change over time, and this is the ideal direction.
	The indicator is trending up with non-significant change over time , and this is the ideal direction.

Priority Area 1: Chronic Disease

Chronic diseases such as heart disease and diabetes are among the leading causes of death and disability in the United States. According to *Healthy People 2030*, these conditions significantly reduce quality of life and contribute to rising healthcare costs. Many chronic diseases are closely linked to behaviors and conditions influenced by social determinants of health—such as poor nutrition, limited physical activity, tobacco use, and barriers to accessing preventive care[15]. Addressing these factors is essential to improving community health outcomes, particularly in populations that face systemic inequities. In Cuyahoga County, chronic disease continues to place a heavy burden on individuals, families, and healthcare systems, reinforcing the need for prevention-focused, community-driven interventions.

Primary Data Findings

Key informant interviews identified that heart disease and diabetes are significant health problems for many individuals living in Cuyahoga County. These issues are especially common in immigrant and refugee communities, pregnant women, and people living in neighborhoods with fewer resources. A large reason for this is many people don't have easy access to healthy food, safe places to exercise, good housing, or affordable healthcare.

> *"High blood pressure and diabetes are being driven by inadequate supports for healthy behaviors. That includes food access, opportunities for physical activity, but then most importantly, stress."*

In many neighborhoods in Cuyahoga County, access to grocery stores with affordable fresh fruits and vegetables is limited. One community member shared, ***"It's not that people don't want to be healthy, but you can buy a whole bunch of processed***

[15] U.S. Department of Health and Human Services. (n.d.). *Chronic diseases*. Healthy People 2030. Office of Disease Prevention and Health Promotion. Retrieved June 15, 2025, from https://health.gov/healthypeople/objectives-and-data/browse-objectives/chronic-diseases

stuff for the same price." These food deserts, combined with poverty, violence, and inadequate housing—create daily stress that can worsen chronic health conditions.

> *Stress has a lot to do with your blood pressure. I'm not a fan of trying to help people manage stress — we need to eliminate the stressors.*

Accessing healthcare is also a challenge for many. Language barriers, long wait times, and lack of transportation often make it difficult to get timely care. As one key informant explained, ***"They don't understand why screenings are important. If I don't feel anything wrong, why should I go?"*** Interviewees stressed the need to shift from reactive care to prevention through culturally relevant health education, trusted community partnerships, and policies that ease everyday burdens.

> *People want to be healthy. Nobody just wants to be sickly and have all these burdens... but we're not doing enough around prevention — we're just treating.*

Secondary Data Findings

Based on secondary data scoring, the topic of *Diabetes* was ranked as the tenth highest scoring health topic in Cuyahoga County, with a score of 1.41; *Heart Disease and Stroke* ranked as the fifteenth highest scoring health need, with a score of 1.27; and, *Other Chronic Conditions* was ranked as the highest scoring health need, with a score of 1.92. Indicators for all three of these topic areas which scored at or above 1.50 were considered indicators of concern and are included in Table 5 below. For a complete list of indicators scored within these topics, see Appendix A.

TABLE 5: DATA SCORING RESULTS FOR CHRONIC DISEASE

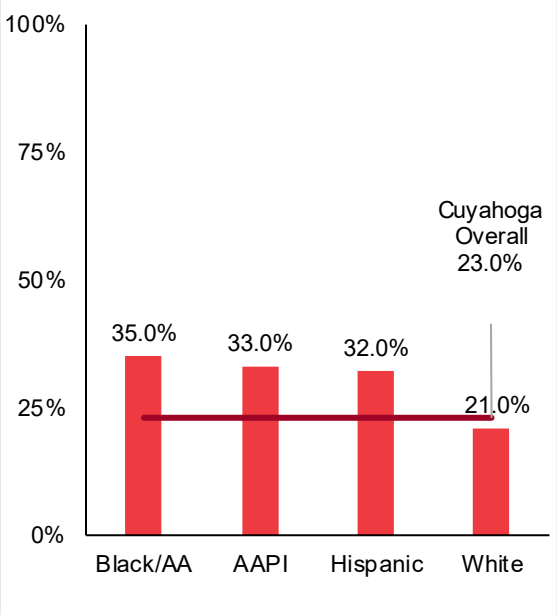
Score	Health Indicator	Units	Cuyahoga County	HP2030	OH	U.S.	OH Counties	U.S. Counties	Trend
2.47	Age-Adjusted Death Rate due to Kidney Disease	*deaths/ 100,000 population*	18.0	-	15.1	-		-	
2.35	Osteoporosis: Medicare Population	*percent*	12.0	-	11.0	11.0			-

2.00	Adults 20+ with Diabetes	*percent*	9.9	-	-	-			
2.00	Stroke: Medicare Population	*percent*	6.0	-	5.0	6.0			-
1.76	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	*deaths/ 100,000 population*	40.8	33.4	46.0	-		-	
1.71	Chronic Kidney Disease: Medicare Population	*percent*	19.0	-	18.0	18.0			-
1.65	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	37.0	-	38.0	35.0			-
1.59	High Blood Pressure Prevalence	*percent*	36.7	41.9	-	32.7			-

About one in ten Cuyahoga County adults age 20+ have either Type 1 or Type 2 diabetes (9.9%). This was the only indicator directly related to diabetes which scored above 1.50. However, we also found concerning rates of kidney disease, which is often caused by diabetes, and could be one indication of gaps in care for individuals with diabetes. In fact, we found that the age-adjusted death rate due to kidney disease in Cuyahoga County is higher than the state average (18.0 vs. 15.1 deaths per 100,000) and is also within the highest quartile of all county rates across Ohio. Stroke is another health issue of concern in this area. The age-adjusted death rate due to stroke is 40.8 deaths per 100,000, a rate which is lower than the state-wide rate (46.0), but higher than the Healthy People 2030 target (33.4).

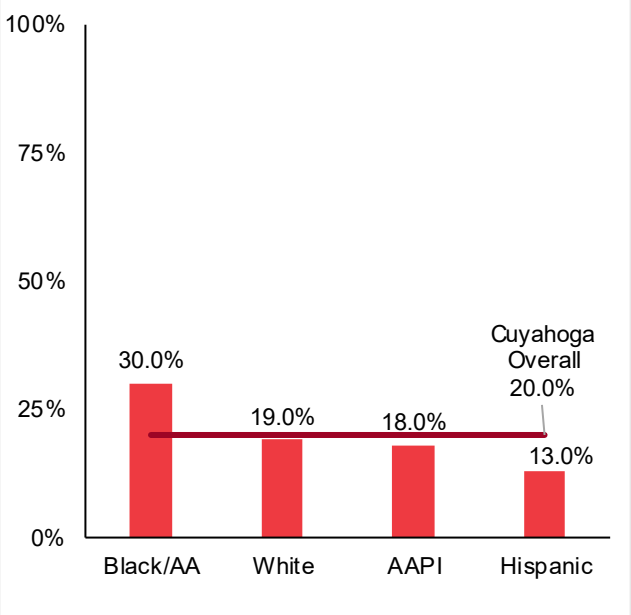
Additional analysis indicates that certain racial/ethnic groups in Cuyahoga County experience greater health risks than the general county-wide population. For example, data concerning Medicare recipients indicate that both diabetes and chronic kidney disease are more common for certain racial/ethnic groups. Compared to the overall county population of Medicare recipients, diabetes is more common among the Black/African American, Asian American/Pacific Islander (AAPI), and Hispanic/Latino Medicare recipients of Cuyahoga County (see Figure 22). Notably, however, chronic kidney disease is only more common among Black/African American Medicare recipients (see Figure 23). This could again indicate a gap in diabetes care and management, specifically for Black/African American residents of Cuyahoga. We also found that the county's Black/African American Medicare population is more likely to experience hypertension (74% vs. 66% of all Medicare recipients; see Figure 24) and the American Indian/Alaska Native (AIAN) Medicare population is more likely to experience ischemic heart disease (27% vs. 21% of all Medicare recipients; see Figure 25). Both of these chronic cardiovascular conditions are also risk factors for stroke.

FIGURE 22: DIABETES: MEDICARE POPULATION BY RACE/ETHNICITY IN CUYAHOGA COUNTY



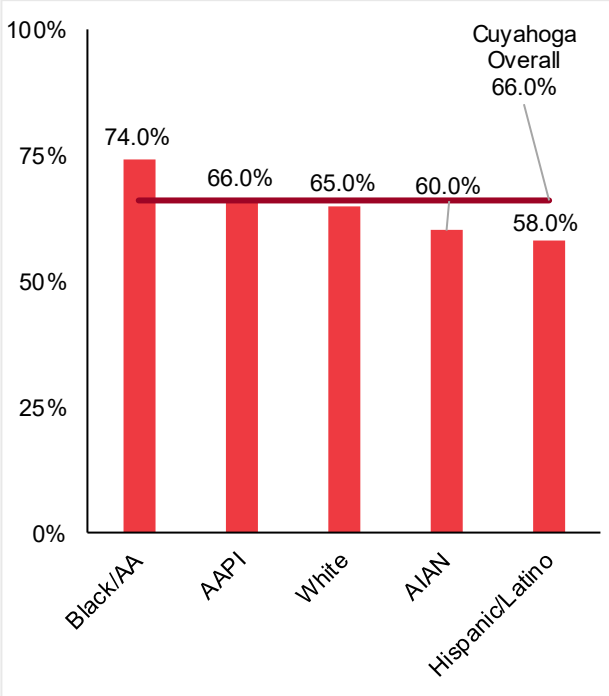
Centers for Medicare & Medicaid Services (2023)

FIGURE 23: CHRONIC KIDNEY DISEASE: MEDICARE POPULATION BY RACE/ETHNICITY IN CUYAHOGA COUNTY



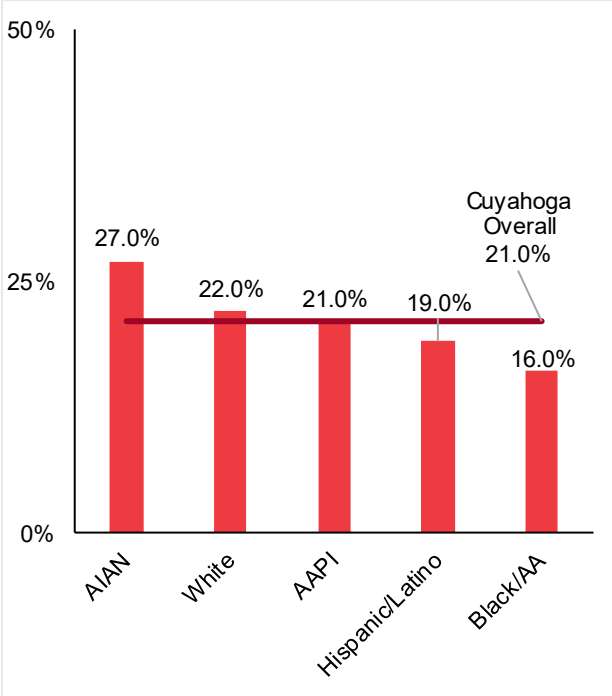
Centers for Medicare & Medicaid Services (2023)

FIGURE 24: HYPERTENSION: MEDICARE POPULATION BY RACE/ETHNICITY IN CUYAHOGA COUNTY



Centers for Medicare & Medicaid Services (2023)

FIGURE 25: ISCHEMIC HEART DISEASE: MEDICARE POPULATION BY RACE/ETHNICITY IN CUYAHOGA COUNTY



Centers for Medicare & Medicaid Services (2023)

Priority Area 2: Maternal and Child Health

Maternal and Child Health emerged as a key priority area during the CHNA process. Although University Hospitals (UH) does not conduct a separate CHNA for UH Rainbow Babies & Children's Hospital or UH MacDonald Women's Hospital, both institutions—part of UH Cleveland Medical Center—will play a central role in addressing health needs related to women, infants, and children. These hospitals bring deep expertise and regional leadership in maternal and pediatric care, making them vital to UH's overall strategy for improving health outcomes across the lifespan.

About UH Rainbow Babies and Children's MacDonald Women's Hospital

UH Rainbow Babies & Children's Hospital is a 244-bed, full-service children's hospital and academic medical center. A trusted leader in pediatric healthcare for more than 130 years, UH Rainbow Babies & Children's Hospital consistently ranks among the top children's hospitals in the nation. As the region's premier resource for pediatric referrals, UH Rainbow Babies & Children's Hospital's dedicated team of more than 1,300 pediatric specialists uses the most advanced treatments and latest innovations to deliver the complete range of pediatric specialty services for 750,000 patient encounters, annually.

UH MacDonald Women's Hospital, located in Cleveland, Ohio, is the state's only hospital dedicated entirely to women's health. As part of the University Hospitals Cleveland Medical Center, it offers comprehensive services ranging from routine gynecological care to specialized treatments for high-risk pregnancies.

Why it Matters:

Healthy People 2030 identifies maternal, infant, and child health as vital to the overall health of communities. Healthy pregnancies and early childhood development reduce the risk of lifelong health problems and improve outcomes across the lifespan. However, many families, especially those in under-resourced areas—struggle to access prenatal care, pediatric services, and support for safe environments. Risk factors like poverty,

racism, food insecurity, and lack of access to healthcare significantly impact birth outcomes, maternal well-being, and child health.[16]

For more information on children's health in Cuyahoga County, please refer to the *Children's Health* section of this report.

Future Directions:

UH will continue to build on existing efforts through its Implementation Strategy, with UH Rainbow Babies & Children's and UH MacDonald Women's Hospital leading targeted interventions.

Primary Data Findings

Key informants emphasized that maternal and child health outcomes in Cuyahoga County remain deeply tied to inequities in the social conditions where families live. Interviewees reported high rates of pregnancy-related hypertension and diabetes, which increase the risk of premature births and maternal deaths. These issues are made worse by food deserts, high stress, poor housing, and limited access to quality prenatal care.

> *High blood pressure and diabetes is being driven by inadequate supports for healthy behaviors. That includes food access, opportunities for physical activity, but then most importantly stress.*

Access to care is a challenge for many pregnant women and families with young children. Even when services exist, transportation, long wait times, and insurance coverage barriers can make it hard to get timely care. One respondent shared, ***"We have access, but do we have access? Because when you don't have a car, your options are very limited, especially with kids."*** There was strong concern that health systems focus too much on treatment and not enough on preventing poor outcomes.

> *We're doing a good job of getting funding to treat problems, but we're not investing enough in preventing those problems in the first place.*

[16] Office of Disease Prevention and Health Promotion. (n.d.). *Maternal, infant, and child health*. Healthy People 2030. U.S. Department of Health and Human Services. Retrieved June 15, 2025, from https://health.gov/healthypeople/objectives-and-data/browse-objectives/maternal-infant-and-child-health

Informants also highlighted the emotional and logistical stress many caregivers face. A parent shared, ***"Even with a two-parent household and my mom's help, our village was stretched. So many of our families can't access their village at all. Everyone's tapped out."*** They explained that working families are forced to choose between childcare, medical care, and income—often sacrificing their own health or their child's needs.

Disparities in infant mortality were identified as especially severe. One expert stated, ***"In Cuyahoga County, Black babies are four times more likely to die in their first year of life than white babies. In Cleveland, that number is up to seven times more likely."*** These outcomes are not just linked to clinical care, but to deeper structural problems such as racism, housing instability, and historical disinvestment. *"You can't talk about infant mortality without talking about poverty, redlining, and systemic racism,"* one informant explained.

Children's health concerns included rising mental health needs following the COVID-19 pandemic, **the harmful effects of lead poisoning, and unsafe housing.**

> *We have to sound the alarm about lead poisoning—it's preventable, but there's no cure once it's in a child's system.*

Participants also emphasized the importance of addressing root causes—like unsafe neighborhoods and lack of economic opportunity—to give children a chance at a healthy future.

There was agreement that while Cuyahoga County has strong hospital systems and community-based programs, those efforts must be matched with deeper investments in prevention, equity, and systems change. Interviewees called for more neighborhood-based care, more culturally relevant education, and stronger efforts to address racism and bias in healthcare delivery. As one participant summarized, *"We cannot expect one system to fix what has been caused by generations of systemic inequality. But health systems can be part of the solution if they listen, partner, and share power with the communities they serve."*

Secondary Data Findings

Secondary data indicators related to maternal and child health were categorized into two topics: *Children's Health* and *Maternal, Fetal, and Infant Health*. Of these, the highest scoring topic was *Children's Health*, with a score of 1.65 that ranked as the fifth highest scoring health need; *Maternal, Fetal, and Infant Health* had a score of 1.51 that ranked as the eighth highest scoring health topic. Indicators scoring at or above 1.50

were considered indicators of concern and are included in Table 6 below. Given the large number of concerning indicators, the discussion of secondary data findings below has been organized into these two respective subtopics. For a complete list of indicators scored within these topics, see Appendix A.

TABLE 6: DATA SCORING RESULTS FOR MATERNAL AND CHILD HEALTH

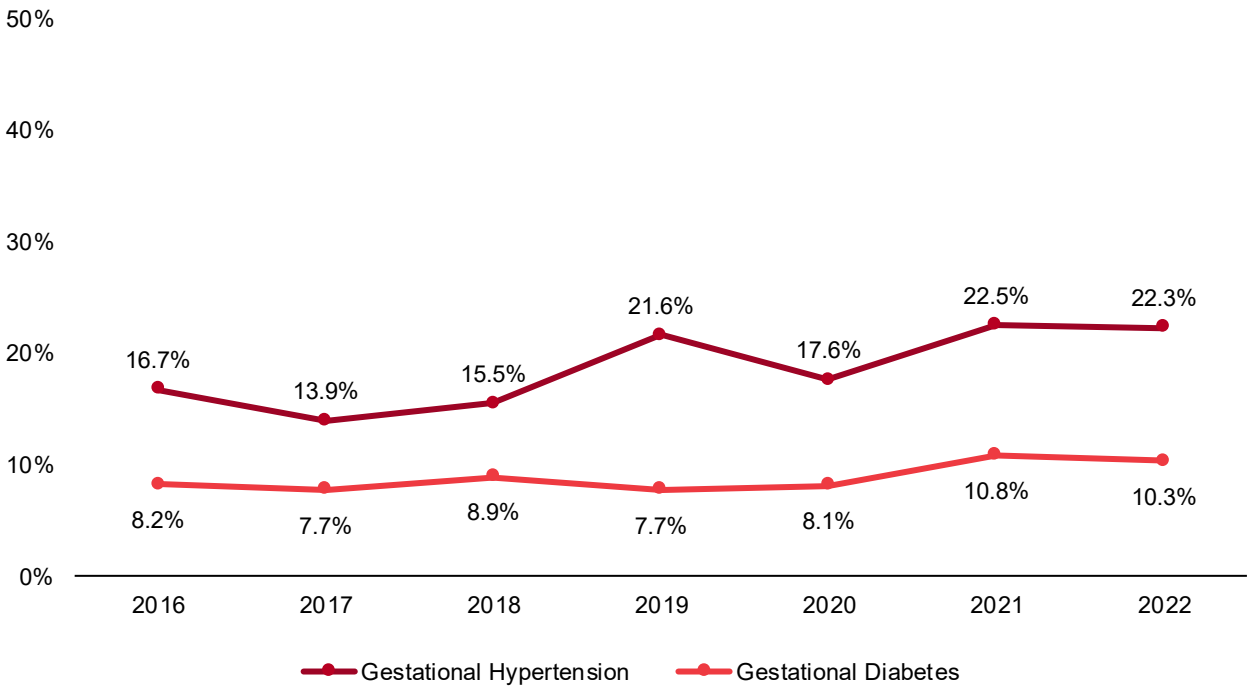
Score	Health Indicator	Units	Cuyahoga County	HP2030	OH	U.S.	OH Counties	U.S. Counties	Trend
2.71	Child Food Insecurity Rate	*percent*	26.7	-	19.8	18.5			
2.44	Babies with Low Birthweight	*percent*	10.8	-	8.7	8.6		-	
2.38	Child Mortality Rate: Under 20	*deaths/ 100,000 population under 20*	70.8	-	58.5	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	-	-	-	

Maternal, Fetal, and Infant Health

Cuyahoga County has a higher teen birth rate than that of Ohio (7.3 vs. 6.1 live births per 1,000 females age 15-17). This rate has been significantly improving over time but is higher than most other county rates across Ohio. Babies born to teens have a higher likelihood of birthing complications and mortality and can also negatively impact the parents' educational and job opportunities.[17] In fact, we found in Cuyahoga County newborns are most likely to have a low birthweight when the birthing parent is 15-17 years old, followed by those 18-19 years old (see Figure 26).

Hypertension and diabetes are also maternal health issues of concern in Cuyahoga County. More than a fifth of mothers (22.3%) report developing hypertension during their pregnancy (i.e., gestational hypertension), which is higher than the Ohio rate (18.3%) and has been increasing significantly over time (see Figure 26). The rate of gestational diabetes has also been increasing, although this increase is less significant and the current rate (10.3%) is similar to the Ohio state-wide average (10.6%).

FIGURE 26: GESTATIONAL HYPERTENSION AND DIABETES OVER TIME IN CUYAHOGA COUNTY



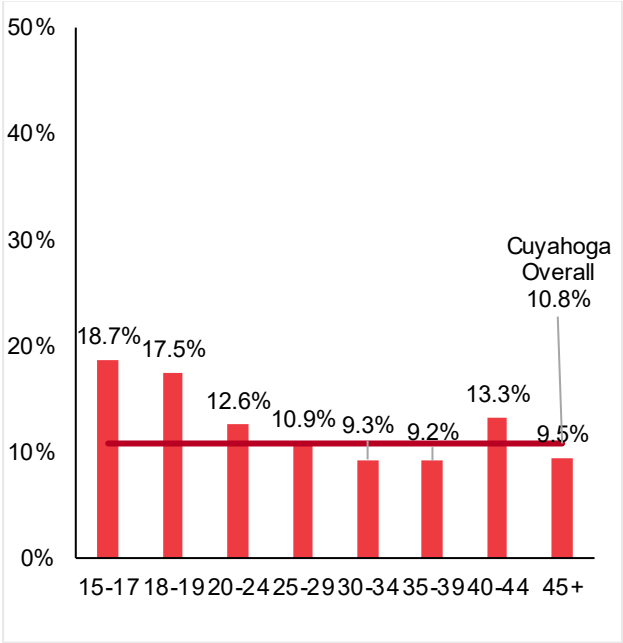
The Ohio Pregnancy Assessment Survey (OPAS) Dashboard

[17] Healthy People 2030. Reduce pregnancies in adolescents. https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/family-planning/reduce-pregnancies-adolescents-fp-03

There are multiple health issues of concern related to birth outcomes in Cuyahoga County. Across the county, 12.0% of births are preterm. This is among the top 25% of highest county rates across the state. About a tenth of births result in a low birthweight for the newborn (10.8%), which is also among the top 25% of highest county rates across Ohio. Infant mortality is also high in Cuyahoga County. The county rate (7.7 deaths per 1,000 live births) is higher than both the Ohio and U.S. rates (6.7 and 5.4, respectively). Although the rates for all three of these birth outcomes are concerning, they have been decreasing over time, though non-significantly.

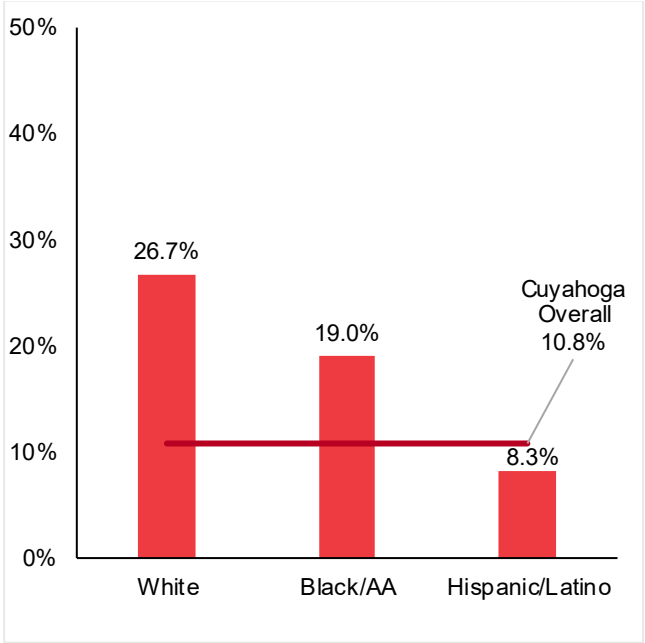
Further analysis indicates that the risk of birthing complications differs by race and ethnicity. Figure 27 shows that both White and Black/African American populations are more likely to have babies with low birthweight. Additionally, we found that the Black/African American population is more likely to have a preterm birth than the overall population (see Figure 28).

FIGURE 26: BABIES WITH LOW BIRTHWEIGHT BY AGE OF BIRTHING PARENT IN CUYAHOGA COUNTY



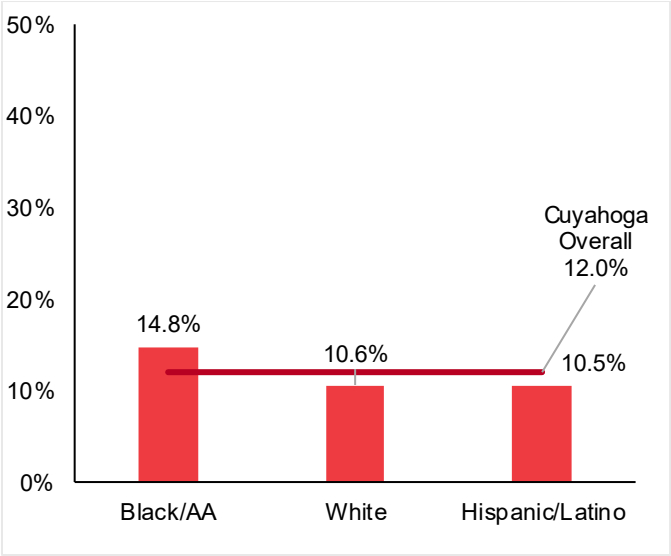
Ohio Department of Health, Vital Statistics (2022)

FIGURE 27: BABIES WITH LOW BIRTHWEIGHT BY RACE/ETHNICITY OF BIRTHING PARENT IN CUYAHOGA COUNTY



Ohio Department of Health, Vital Statistics (2022)

FIGURE 28: PRETERM BIRTHS BY RACE/ETHNICITY OF BIRTHING PARENT IN CUYAHOGA COUNTY

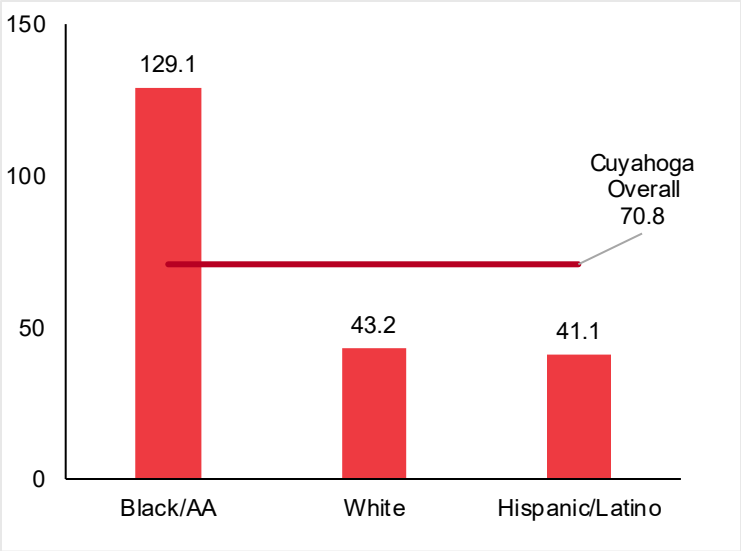


Ohio Department of Health, Vital Statistics (2022)

Children's Health

One of the most concerning health issues related to children in Cuyahoga County is the child mortality rate. Cuyahoga's population under 20 years old has an overall death rate of 70.8 deaths per 100,000. This is higher than the Ohio rate (58.5) and is among the highest county rates across the state. This mortality rate also differs significantly by race and ethnicity. Black/African American children in Cuyahoga have a risk of death that is more than three times higher than that of White and Hispanic/Latino children (see Figure 29).

FIGURE 29: CHILD MORTALITY RATE BY RACE/ETHNICITY IN CUYAHOGA COUNTY (DEATHS PER 100,000 POPULATION UNDER 20)

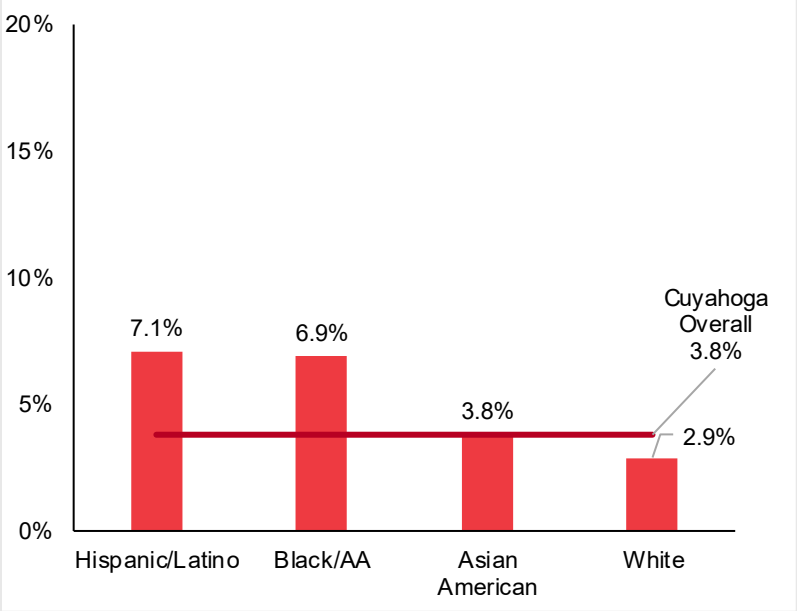


County Health Rankings (2018-2021)

Some of the most concerning issues impacting children in Cuyahoga are socioeconomic factors that may limit needed care and nutrition. More than a quarter of children in Cuyahoga County experience food insecurity (26.7%), which is one of the highest county rates across Ohio. The cost of home childcare is also particularly expensive in Cuyahoga. Across the county, the cost of home childcare is about 3.8% of one's household income, which is a higher rate than most other counties across the state. Affordable childcare is essential for caretakers to be able to provide basic needs and participate in the workforce or further their education.[18] These costs can be particularly burdensome for the Hispanic/Latino and Black/African American populations of Cuyahoga County, as seen in Figure 30.

[18] County Health Rankings. Childcare cost burden. https://www.countyhealthrankings.org/health-data/community-conditions/social-and-economic-factors/safety-and-social-support/child-care-cost-burden?year=2025

FIGURE 30: HOME CHILD CARE SPENDING-TO-INCOME RATIO BY RACE/ETHNICITY IN CUYAHOGA COUNTY (AVERAGE CHILD CARE SPENDING AS A PERCENTAGE OF MEDIAN HOUSEHOLD INCOME)



Claritas Consumer Spending Dynamix (2024)

Priority Area 3: Wellbeing

Wellness and lifestyle play a vital role in preventing chronic diseases, improving mental health, and supporting healthy aging. According to Healthy People 2030, healthy eating patterns, regular physical activity, and maintaining a healthy weight are key to living a longer, healthier life. However, access to healthy food and safe places to be active is not equal in every community. Many people—especially those in underserved neighborhoods—face barriers such as food deserts, unsafe housing, low income, and lack of access to healthcare, which makes it harder to adopt healthy behaviors[19].

Primary Data Findings

Key informants shared that wellness and physical health are deeply affected by the environments where people live, work, and play. Many communities in Cuyahoga County lack full-service grocery stores, affordable fresh produce, and safe spaces to walk or exercise.

> It's much cheaper to buy processed foods than it is to buy fresh produce... Not because folks don't want to be healthy, but because you can buy a whole bunch of processed stuff for the same amount of money.

Food apartheid are common in many low-income areas, especially where transportation is limited. Residents without a car often rely on corner stores that don't carry nutritious options. Informants also noted that high food prices make healthy eating hard for families on a fixed income. **"If I were on a fixed income, I'm not buying a pound of grapes for $8 when I have to feed myself and my kids,"** said one interviewee.

In terms of physical activity, many residents face barriers to exercise such as lack of nearby gyms, safe sidewalks, or warm indoor spaces during the winter. **"Community centers should be places where folks can gather, which also helps with isolation and creates social connections,"** one person suggested. They added that even small

[19] Office of Disease Prevention and Health Promotion. (n.d.). *Nutrition and healthy eating*. Healthy People 2030. U.S. Department of Health and Human Services. Retrieved June 15, 2025, from https://health.gov/healthypeople/objectives-and-data/browse-objectives/nutrition-and-healthy-eating

steps like “lunchtime chair yoga” could make wellness more accessible if offered in neighborhoods, not just in hospitals.

Mental and emotional wellness also came up as major factors. Informants said stress, trauma, and social isolation are major reasons people don’t feel well or struggle to stay healthy.

> “Stress has a lot to do with your blood pressure... I’m not a fan of helping people manage stress. I want to eliminate the stressors.”

They noted that people often crave “quick comfort” foods in high-stress environments, which makes obesity harder to prevent. Other challenges include limited health literacy, lack of health insurance, and difficulty navigating wellness programs. Many informants emphasized that wellness efforts need to be culturally relevant, community-driven, and easily accessible. Suggestions included mobile farmers markets, walking clubs, and incentive programs like step-tracking apps with grocery vouchers. As one person said, **“We already have good park systems and resources—now we need to make them easier to access and more consistent across the whole county”.**

Secondary Data Findings

Secondary data indicators related to wellbeing were categorized primarily into three topics: *Nutrition and Healthy Eating*, *Physical Activity*, and *Wellness and Lifestyle*. Of these topics, the most concerning was *Wellness and Lifestyle* which had a score of 1.64, ranking as the sixth highest scoring health topic. The topics *Nutrition and Healthy Eating* and *Physical Activity* had scores of 1.40 and 0.82, respectively. Indicators scoring at or above 1.50 were considered indicators of concern and are included in Table 7 below. For a complete list of indicators scored within these topics, see Appendix A.

TABLE 7: DATA SCORING RESULTS FOR WELLBEING

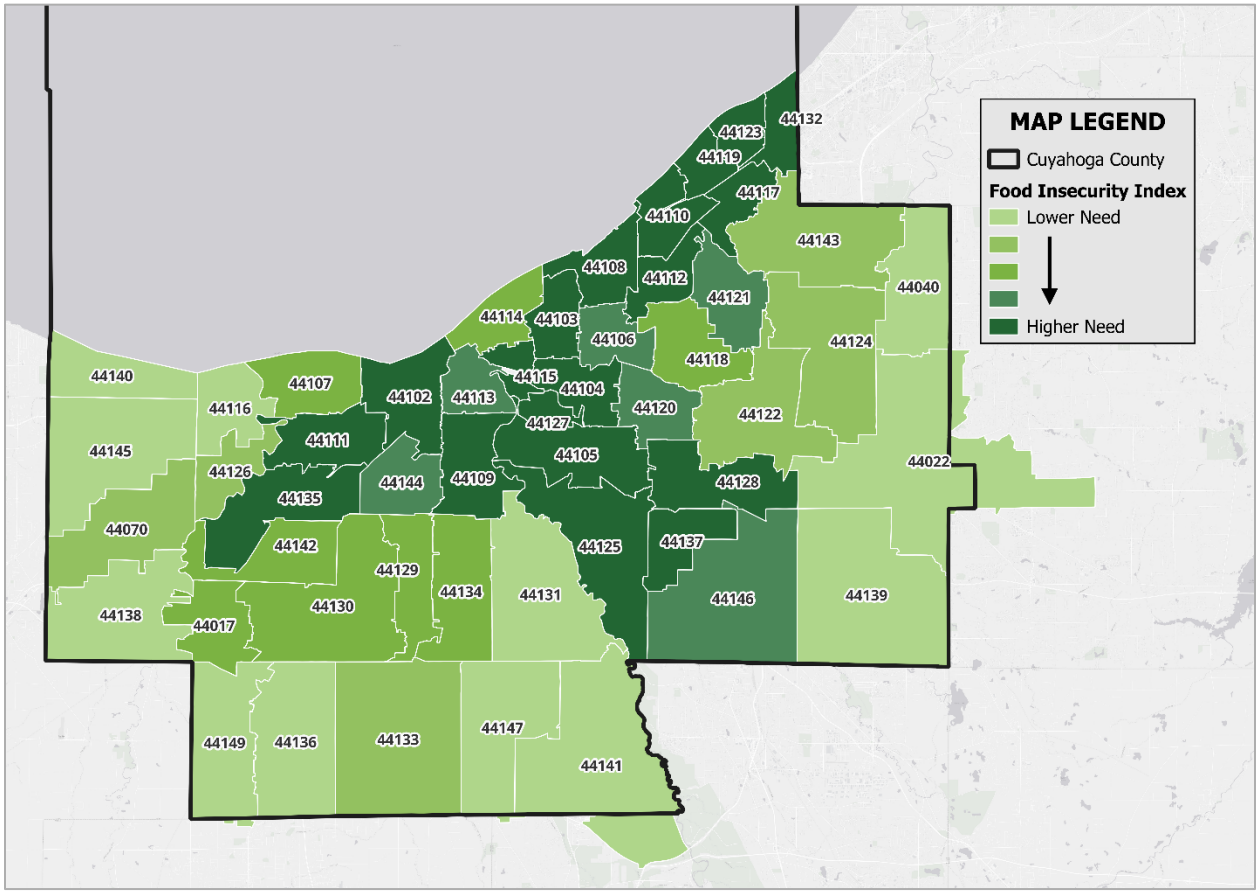
Score	Health Indicator	Units	Cuyahoga County	HP2030	OH	U.S.	OH Counties	U.S. Counties	Trend
2.29	Self-Reported General Health Assessment: Good or Better	*percent*	84.2	--	85.4	86.0			--
2.21	Adults who Frequently Cook Meals at Home	*Percent*	66.2	--	67.6	67.7			
2.06	Poor Physical Health: Average Number of Days	*days*	4.0	--	3.6	3.3			

1.76	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	*Percent*	39.6	--	38.1	38.2			
1.74	Obesity: Medicare Population	*percent*	24.0	--	24.0	19.0		--	--
1.59	High Blood Pressure Prevalence	*percent*	36.7	41.9	--	32.7			--
1.59	Insufficient Sleep	*percent*	37.7	26.7	--	36.0			--
1.59	Self-Reported General Health Assessment: Poor or Fair	*percent*	20.1	--	--	17.9			--
1.50	Adults who Feel Life is Slipping Out of Control	*Percent*	24.1	--	24.1	23.9			--
1.50	Life Expectancy	*years*	75.7	--	75.6	77.6			--

Compared to the overall Ohio population, Cuyahoga residents are less likely to report good general health. For example, 84.2% of the Cuyahoga population report that their general health is good or better, a county rate which is lower than most other Ohio counties and has also been significantly decreasing over time. Cuyahoga adults are also less likely to cook meals at home, and are more likely to use quick service restaurants, compared to the overall Ohio and U.S. populations. However, the percentage of adults frequently using quick service restaurants has been significantly decreasing over time. Eating out more and cooking at home less may mean a less balanced, fresh, and healthy diet for Cuyahoga residents, which is essential to promote better health outcomes.

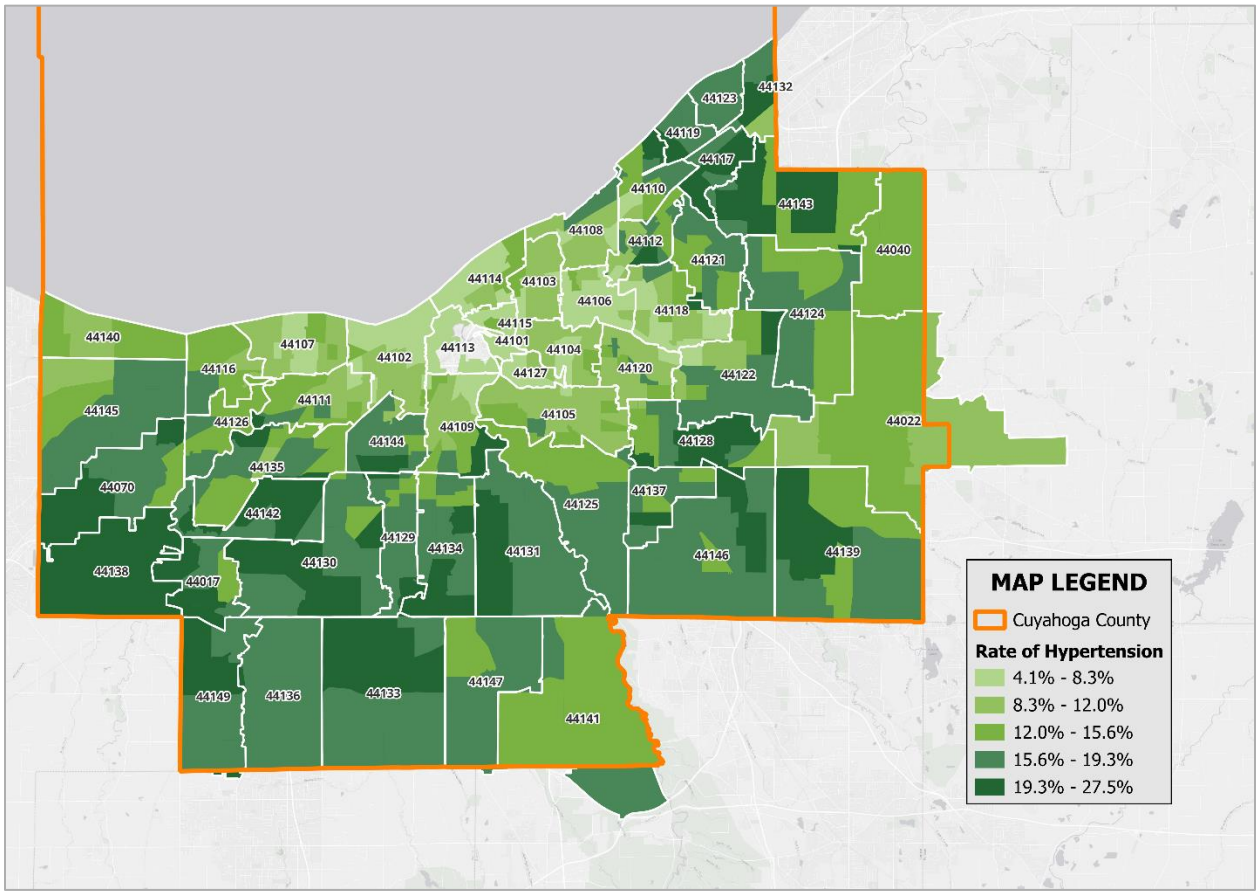
Conduent's Food Insecurity Index (CHI) uses socioeconomic data to estimate which zip codes are most likely to experience hardship related to food access. These index values range from 0 to 100, based on how each zip code compares to other zip codes across the country. Each zip code is also locally ranked, as seen in Figure 31, based on its index value to identify relative levels of need across the county. Darker shades of green indicating a greater predicted rate of food insecurity. The zip codes in Cuyahoga with the highest index values are 44104 and 44115, with index values of 100.0 and 99.9, respectively. Notably, more than half of Cuyahoga's zip codes (60.8%) have an index value of 50 or above. (see Appendix A for full table of index values).

FIGURE 31: FOOD INSECURITY INDEX



Just over a third of Cuyahoga's population has high blood pressure (36.7%), which is higher than the overall U.S. rate, but meets the Healthy People 2030 target of 41.9%. Hospital intake data indicate that certain regions of Cuyahoga have especially high rates of high blood pressure, as indicated by the darkest shades of green in Figure 32.

FIGURE 32: ESTIMATED RATE OF HYPERTENSION AMONG ALL INDIVIDUALS IN CUYAHOGA COUNTY BY ZIP CODE



Priority Population: Older Adults

Older adults are living longer than ever, but many face serious health challenges as they age. According to Healthy People 2030, promoting the health and well-being of older adults is critical to increasing quality of life, maintaining independence, and reducing healthcare costs. Cuyahoga County has a relatively higher percentage of residents age 65 and above (20.9%), compared to both Ohio (19.8%) and the U.S. (16.8%). It is estimated by 2030, close to 30% of residents in Cuyahoga County, over 400,000 people, will be age 60 or over. As people age, they are more likely to develop chronic conditions such as heart disease, diabetes, obesity, and dementia. Supporting older adults means improving access to healthcare, safe housing, transportation, nutritious food, social connections, and community resources[20].

Primary Data Findings

Key informants across Cuyahoga County reported that older adults face multiple barriers to good health, especially those living in poverty or underserved areas. These challenges include managing chronic conditions, staying socially connected, accessing transportation, and affording healthy food or housing.

> “The older adult population has higher levels of obesity and struggles with managing chronic diseases. Social isolation is a big issue—not just for the older adults, but also for their family caregivers.”

Many older adults live alone or are homebound, especially those with dementia. One interviewee noted, **“About one-fourth of people with dementia live alone. They’re isolated, and many don’t have someone to help them navigate care.”** In lower-

> “If you don’t have a sidewalk to walk on or a park nearby, it’s much harder to stay active or eat well.”

[20] Office of Disease Prevention and Health Promotion. (n.d.). *Older adults*. Healthy People 2030. U.S. Department of Health and Human Services. Retrieved June 15, 2025, from https://health.gov/healthypeople/objectives-and-data/browse-objectives/older-adults

income neighborhoods, older adults often lack access to parks, sidewalks, and fresh food.

Access to healthcare is another concern. While most older adults qualify for Medicare, many did not have health insurance earlier in life and are unfamiliar with navigating the system. One provider said, **"If you didn't have regular health coverage until you turned 65, it's hard to know how to use the system. A lot of our older clients never had a primary doctor."** Transportation to non-emergency appointments remains a barrier, and some are uncomfortable with telehealth or don't have the technology to use it.

Mental health was also raised as a growing issue. Depression, loneliness, and reluctance to seek behavioral health support are common.

> "There's still stigma around asking for help. Some older adults just don't want to talk about mental health."

Despite these challenges, community-based programs play an essential role in supporting older adults. Initiatives like Meals on Wheels, wellness programs at senior centers, and housing support services were highlighted as crucial. As one stakeholder summarized, **"What helps older adults—like curb cuts, safe sidewalks, or access to community centers—also helps everyone. These are investments in health for all generations."**

Secondary Data Findings

Based on secondary data scoring, the topic *Older Adults* ranked as the fourth highest scoring health topic with a score of 1.67. Indicators scoring at or above 1.50 were considered indicators of concern and are included in Table 8 below. For a complete list of indicators scored within this topic, see Appendix A.

TABLE 8: DATA SCORING RESULTS FOR OLDER ADULTS

Score	Health 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			
3.00	Prostate Cancer Incidence Rate	*cases/ 100,000 males*	139.3		118.1	113.2			
2.82	People 65+ Living Below Poverty Level	*percent*	12.3		9.5	10.4			

2.38	Adult Day Care Spending-to-Income Ratio	*percent*	13.4		11.3	12.3		 
2.35	Cancer: Medicare Population	*percent*	13.0		12.0	12.0		 --
2.35	Osteoporosis: Medicare Population	*percent*	12.0		11.0	11.0		 --
2.00	Asthma: Medicare Population	*percent*	7.0		6.0	7.0		 --
2.00	Breast Cancer Incidence Rate	*cases/ 100,000 females*	136.1		132.3	129.8		 
2.00	Stroke: Medicare Population	*percent*	6.0		5.0	6.0		 --
1.71	Chronic Kidney Disease: Medicare Population	*percent*	19.0		18.0	18.0		 --
1.65	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	37.0		38.0	35.0		 --
1.59	Adults 65+ with Total Tooth Loss	*percent*	13.9			12.2		 --

Some of the most concerning health issues for older adults in Cuyahoga are chronic conditions such as heart disease and kidney disease, as discussed in more detail under the *Chronic Disease* prioritized health topic. Prostate cancer is also particularly burdensome for Cuyahoga residents. The county-wide incidence of prostate cancer is 139.3 cases per 100,000 males, which is substantially higher than the state-wide rate (118.1), and also one of the highest county rates across the state.

Hospital intake data helps to illustrate how cancer incidence varies geographically across the county. For example, although prostate cancer is relatively common across Cuyahoga County, hospital intakes related to prostate cancer are most likely to come from patients residing in zip codes 44122, 44124, and 44145 (see Figure 33).

FIGURE 33: ESTIMATED RATE OF PROSTATE CANCER AMONG ALL INDIVIDUALS IN CUYAHOGA COUNTY BY ZIP CODE

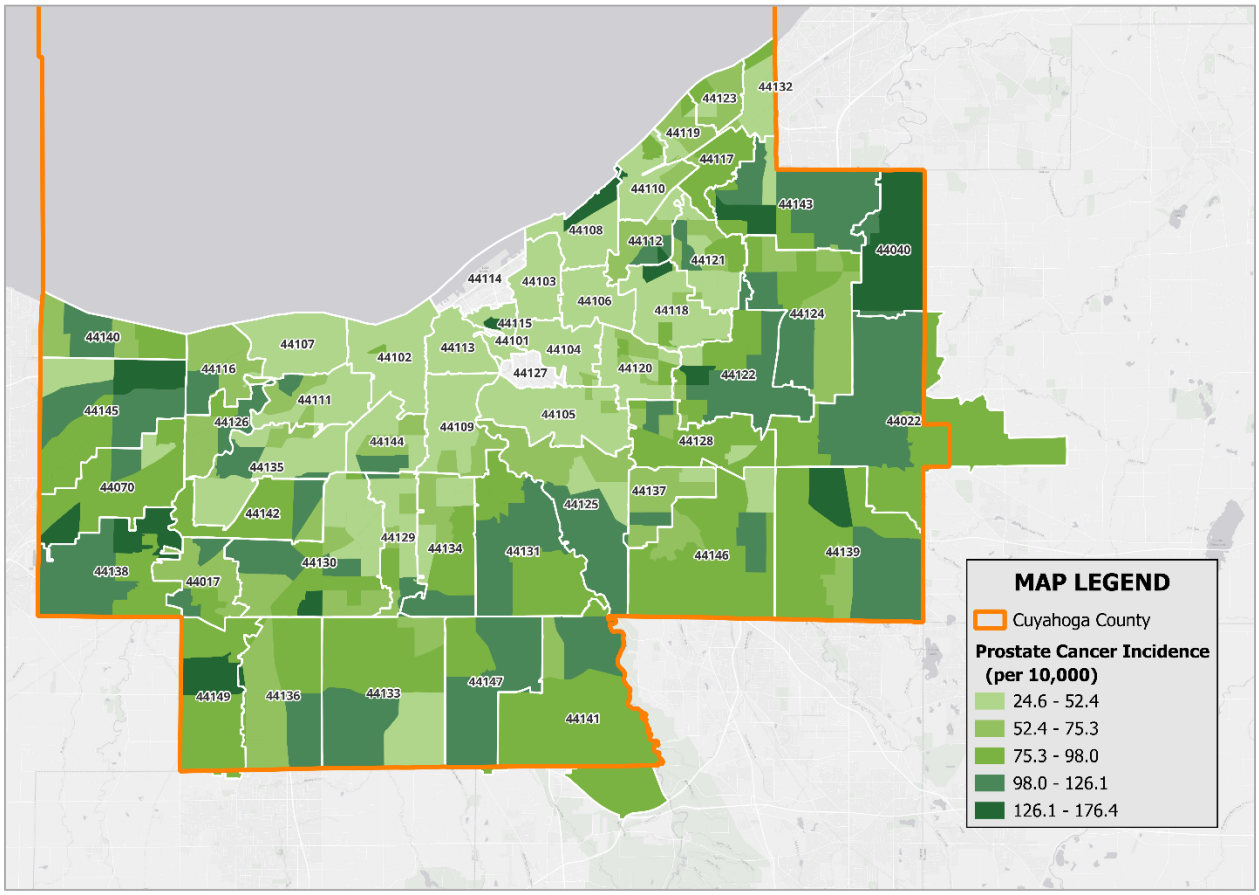


FIGURE 34: ESTIMATED RATE OF BREAST CANCER AMONG ALL INDIVIDUALS IN CUYAHOGA COUNTY BY ZIP CODE

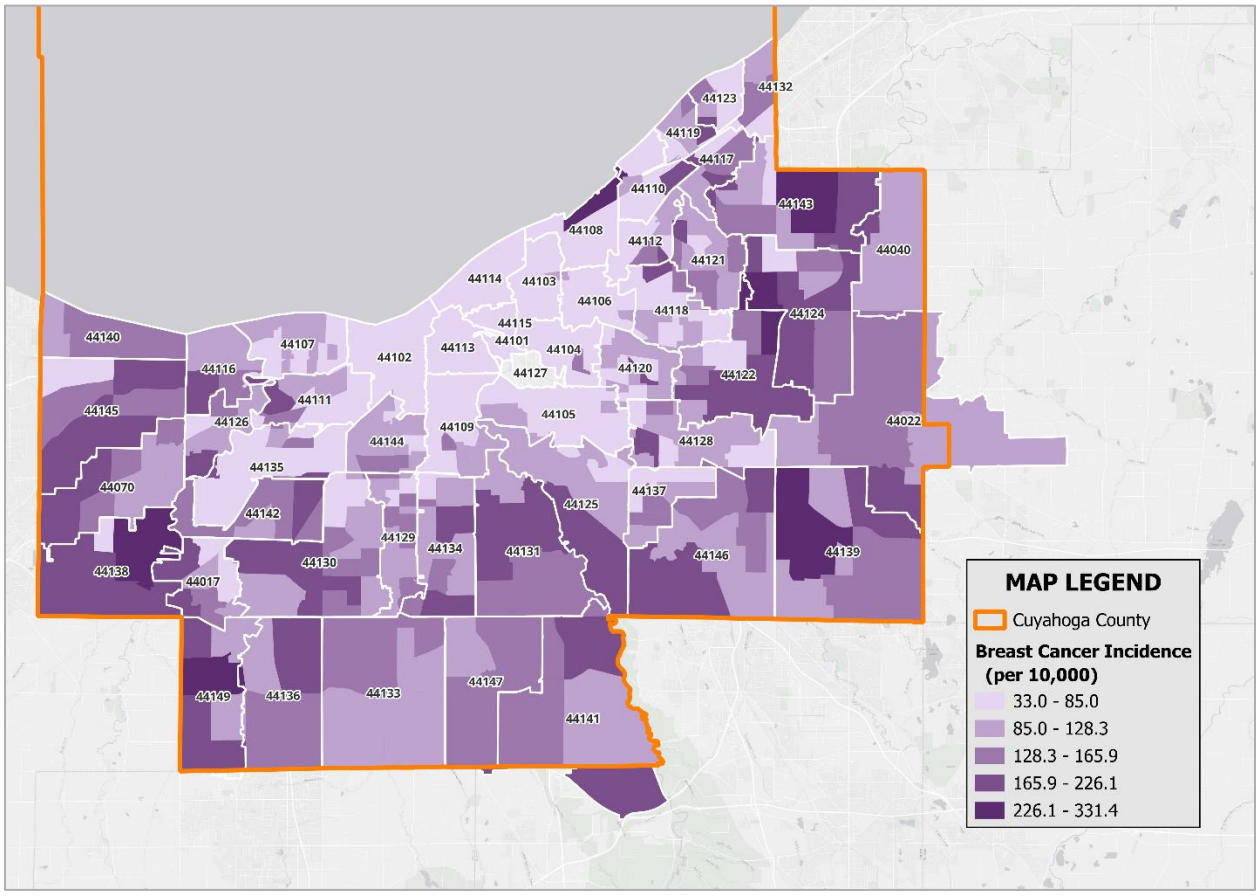
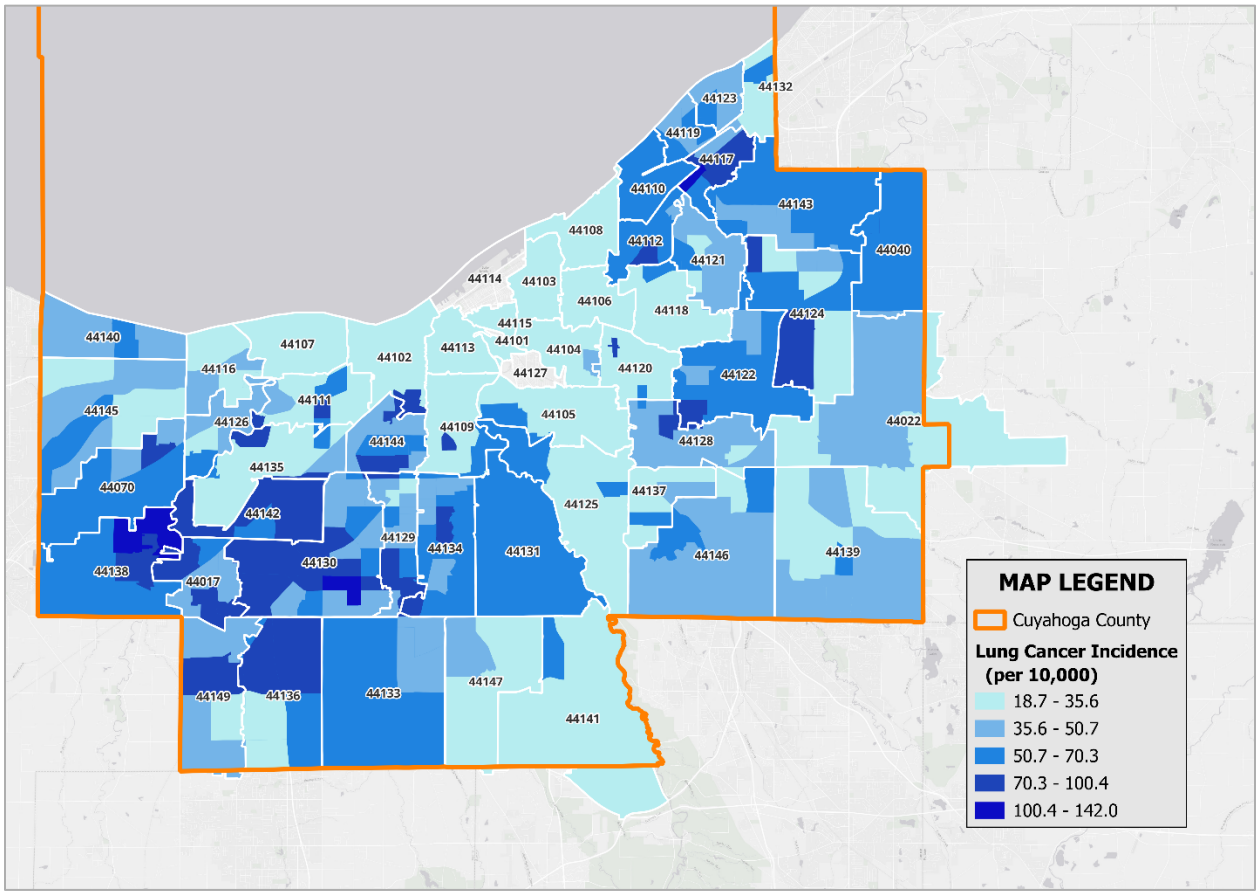
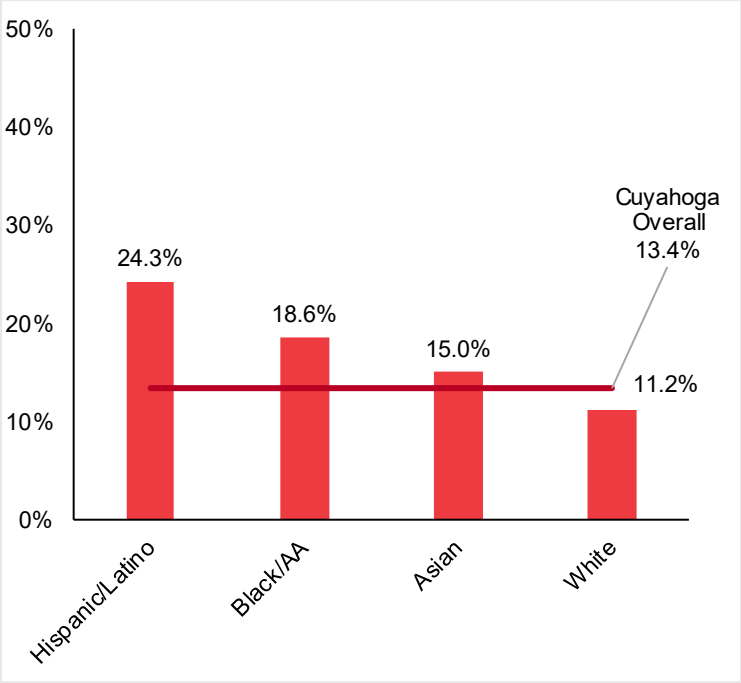


FIGURE 35: ESTIMATED RATE OF LUNG CANCER AMONG ALL INDIVIDUALS IN CUYAHOGA COUNTY BY ZIP CODE



Isolation is also a challenge for Cuyahoga's older adult population. More than a third of adults age 65 and above live alone (36.1%), which is substantially higher than the state-wide and nation-wide rates (30.2% and 26.5%, respectively). The cost of providing care for older adults is relatively high in Cuyahoga. On average, the cost of adult day care is 13.4% of one's household income, which is one of the highest rates across all Ohio counties. This care may be especially costly for the county's Hispanic/Latino population, whose typical cost of adult day care is 24.3%, or nearly twice that of the overall county population (see Figure 36).

FIGURE 36: ADULT DAY CARE SPENDING-TO-INCOME RATIO BY RACE/ETHNICITY IN CUYAHOGA COUNTY



Claritas Consumer Spending Dynamix, 2024

Other Health Needs of Concern

The following significant health needs, presented in alphabetical order, emerged from a review of the primary and secondary data. University Hospitals (UH) did not elect to explicitly prioritize these topics. However, they are related to the selected priority areas and will be interwoven in the forthcoming Implementation Strategy and in future work addressing health needs through strategic partnerships with community partners.

Key themes from community input are included for other health needs along with the secondary data warning indicators, which reveal where Cuyahoga County performs worse than the state of Ohio.

Cancer

Healthcare Access and Quality

Mental Health and Mental Disorders

Substance Use

Sexually Transmitted Infections

Cancer

About Seidman Cancer Center

University Hospitals Seidman Cancer Center is the only freestanding hospital in Northeast Ohio dedicated exclusively to the diagnosis and treatment of cancer and hematologic disorders. With 18 locations across the region, UH Seidman Cancer Center provides patients with a full continuum of care, close to home.

UH does not conduct a separate Community Health Needs Assessment (CHNA) specifically for Seidman. Although cancer was not identified as a prioritized health need in the overall assessment, it remains a key focus for the Seidman Cancer Center and will continue to be a priority. Cancer care will also be integrated into the focus on the priority population of older adults, as highlighted in the section above, which shows a high prevalence of prostate, breast, and lung cancers among this group. This focus will guide the Seidman Cancer Center's efforts moving forward. For more details, please refer to Figures 33-35 above, which illustrate cancer prevalence by zip code in older adults.

Cancer is the second leading cause of death in the United States. Many types of cancer can be prevented or found early through regular checkups and screenings. Healthy habits, like not smoking, eating nutritious food, and staying active, also help lower cancer risk. Healthy People 2030 aims to reduce new cancer cases and increase the number of people who survive. It also focuses on improving the conditions that affect health, such as access to care and healthy environments.[21]

Primary Data Findings

Key informants shared many concerns about cancer during the interviews. One of the biggest issues mentioned was smoking and how it leads to several health problems, including lung cancer and heart disease. **Smoking-related illnesses are more common in certain parts of the community, especially in Cleveland**. Participants said that cancer and other chronic illnesses are deeply tied to poverty, stress, and unhealthy environments.

[21] U.S. Department of Health and Human Services. (n.d.). *Cancer - Healthy People 2030*. Office of Disease Prevention and Health Promotion. Retrieved from https://health.gov/healthypeople/objectives-and-data/browse-objectives/cancer

Access to cancer care is not equal across neighborhoods. Interviewees noted that some people have difficulty reaching top hospitals or affording the services they need. Large hospitals may offer high-quality care but getting there can be difficult without reliable transportation. For people with lower incomes, even parking fees or the cost of food at hospitals can be a burden. Many residents feel that hospitals are better designed for people with money or private insurance, rather than everyday families.

Prevention and screening are also major concerns. Key informants expressed that some immigrants and refugees may not understand why cancer screenings are important if they aren't feeling sick. This can result in late diagnoses. Many people in these communities come from countries where prevention is not part of the healthcare system, and they may also struggle with low health literacy, language barriers, and limited transportation. There is a need for more health education in a culturally sensitive way, as well as better support services to help people keep up with their care.

Informants also talked about how the environment contributes to cancer. For example, exposure to air pollution, lead, and poor-quality housing were mentioned as serious risks. These problems are more common in underinvested areas where mostly Black and low-income families live. Some residents live near old buildings with lead, or in neighborhoods with few green spaces or healthy food options. These factors increase long-term cancer risks and affect overall health.

Lastly, several participants expressed frustration with how the healthcare system invests more in treatment than prevention. They believe that more money should go toward community education, healthy environments, and early screenings. By focusing on prevention, the healthcare system could lower cancer rates and improve health for everyone, especially in vulnerable neighborhoods.

Secondary Data Findings

The topic *Cancer* ranked as the 13th highest scoring health topic in Cuyahoga County, with a score of 1.38. See Appendix A for a full table of indicators scored within this topic area. The following are indicators of concern, which scored at or above 1.50:

- Prostate Cancer Incidence Rate
- Cancer: Medicare Population
- Age-Adjusted Death Rate due to Prostate Cancer
- Breast Cancer Incidence Rate
- Age-Adjusted Death Rate due to Breast Cancer
- All Cancer Incidence Rate

For additional geographic information about where cancer is most common across the county, see the section *Priority Population Older Adults*.

Healthcare Access and Quality

Access to quality healthcare helps people stay healthy, manage illnesses, and avoid preventable hospital visits. According to Healthy People 2030, people with access to primary care providers, timely services, and affordable health insurance are more likely to receive the preventive services and treatments they need. However, barriers like cost, discrimination, transportation, long wait times, and lack of culturally sensitive care can limit access—especially for people with low income or from underserved communities.[22]

Primary Data Findings

Key informants across Cuyahoga County shared that while the region has strong hospital systems and health centers, many people still face serious challenges in accessing care. Transportation is a major concern. If residents don't have a car or reliable public transit, it becomes difficult to get to doctor's appointments, especially for non-emergency visits. Telehealth helps in some cases, but not everyone has internet access or is comfortable using technology.

Cost and insurance are other barriers. While Medicaid expansion has helped more people get covered, it hasn't solved the issue of finding providers who accept Medicaid or offer appointments in a timely manner. Many people delay care because they can't afford copays, don't understand their insurance, or are discouraged by past negative experiences with the system.

A major concern raised was the quality of care, especially for Black women and other marginalized groups. Interviewees described experiences of being dismissed, judged, or treated with disrespect by healthcare providers. These negative encounters make people less likely to seek care again, even when they need it. Several noted a lack of culturally competent care and training among healthcare professionals, particularly around bias, communication, and patient respect.

Stakeholders called for more accountability and community involvement in how health systems deliver care. They recommended building stronger patient-provider relationships, increasing transparency, training providers in cultural humility, and

[22] Office of Disease Prevention and Health Promotion. (n.d.). *Access to health services*. Healthy People 2030. U.S. Department of Health and Human Services. Retrieved June 15, 2025, from https://health.gov/healthypeople/objectives-and-data/browse-objectives/health-care-access-and-quality

ensuring more services are offered in trusted community spaces. Community members want to be listened to, respected, and cared for in ways that recognize their lived experiences and needs.

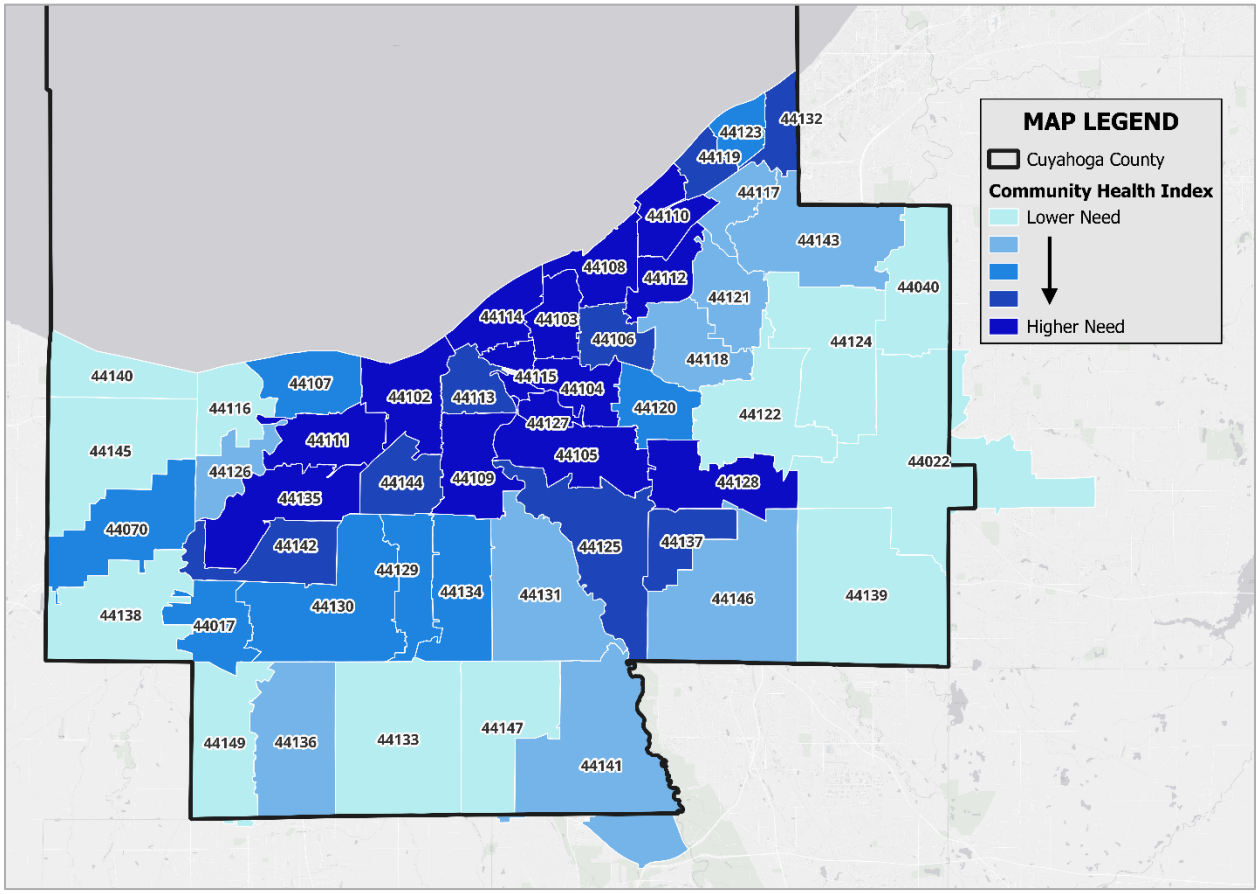
Secondary Data Findings

The topic *Health Care Access and Quality* Ranked as the 16th highest scoring health topic in Cuyahoga County, with a score of 1.24. See Appendix A for a full table of indicators scored within this topic area. The following are indicators of concern, which scored at or above 1.50:

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

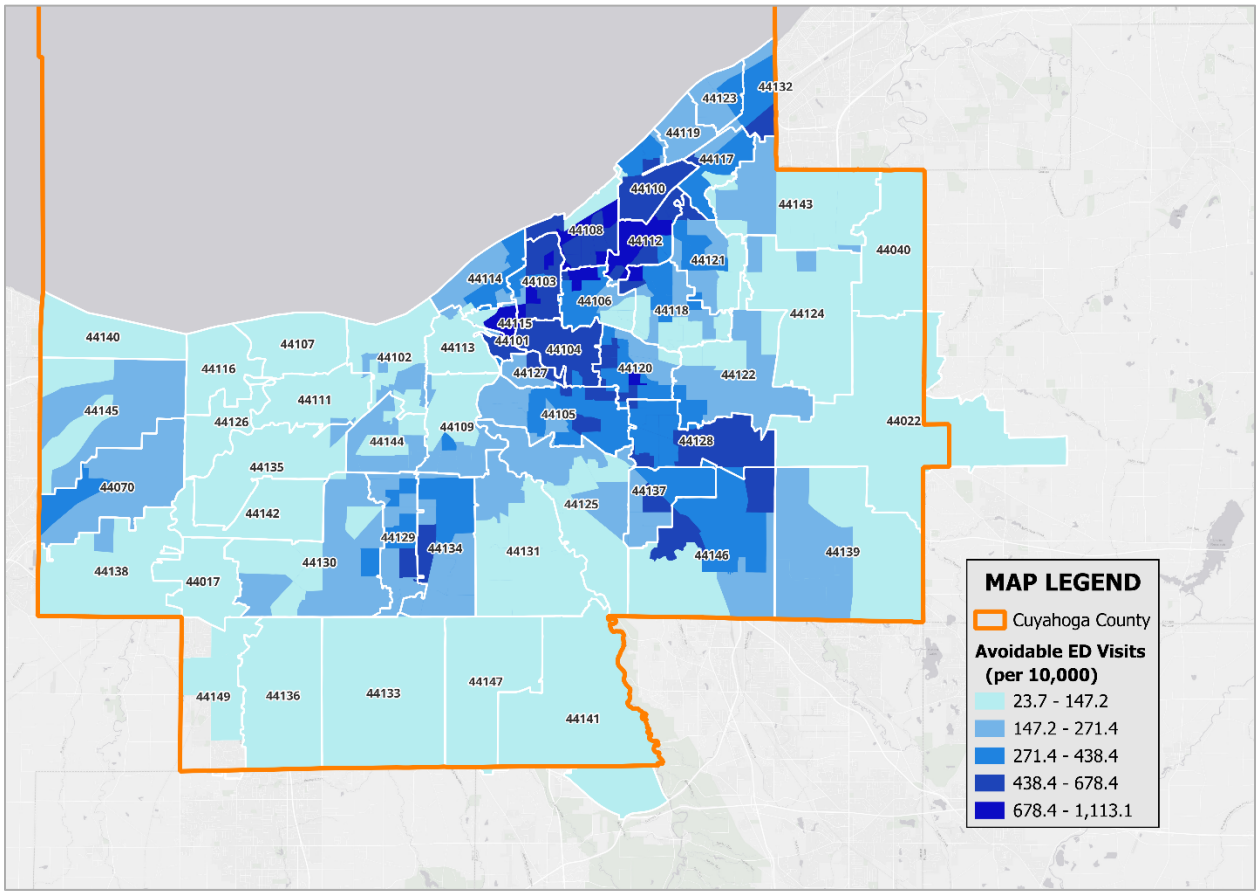
Conduent's Community Health Index (CHI) can help to estimate which regions of Cuyahoga County are more likely to experience poor healthcare access and quality. The CHI uses socioeconomic data to estimate which zip codes are at greatest risk for poor health outcomes, such as preventable hospitalization or premature death. Index values range from 0 to 100, based on how each zip code compares to others across the country. Each zip code is also locally ranked, as seen in Figure 37, based on its index value to identify relative levels of need across the county. Darker shades of blue indicate greater levels of need. The zip codes in Cuyahoga with the highest index values are 44115 and 44104, with index values of 99.9 and 99.8, respectively. See Appendix A for a full table of index values.

FIGURE 37: COMMUNITY HEALTH INDEX



When residents have poor access to routine care, it may result in ED visits that may have otherwise been avoidable. Figure 38 uses hospital intake data to map out where avoidable ED visits are most common across the county.

FIGURE 38: ESTIMATED AVOIDABLE ED VISITS AMONG ALL INDIVIDUALS IN CUYAHOGA COUNTY BY ZIP CODE



Mental Health and Mental Disorders

Mental health is a key part of overall health. It affects how people think, feel, act, and handle stress. Mental disorders like depression, anxiety, and substance use can interfere with daily life and relationships. Healthy People 2030 works to improve mental health by increasing access to care and reducing stigma. The goal is to help people live healthier, more productive lives.[23]

Primary Data Findings

Key informants shared that mental health concerns have increased in recent years, especially since the COVID-19 pandemic. More people are feeling anxious, overwhelmed, and socially isolated. Young people, in particular, are asking for help more often than they did before. Informants also noted that stigma around mental illness is improving slightly, with more open conversations happening in families and communities.

However, there are still big challenges. Many people cannot get the mental health care they need because of long wait times, lack of insurance, or not enough providers. In some neighborhoods, services are far away, and public transportation is limited. Some families don't know where to turn for help or feel confused by the healthcare system. People of color and immigrants often experience barriers related to cultural understanding, trust, and provider diversity.

Several interviewees said that the mental health system needs to be more focused on the individual. Right now, people are often discharged from hospitals quickly, even if they are not ready, due to system capacity or cost pressures. This can cause setbacks in recovery. Others highlighted the need for better follow-up care and stronger connections between hospitals and community-based services.

Stress from poverty, unsafe housing, food insecurity, and violence was also mentioned as a major contributor to mental illness. Living in these conditions can create trauma and long-term health problems. Many residents are juggling jobs, caregiving, and

[23] U.S. Department of Health and Human Services. (n.d.). *Mental health and mental disorders - Healthy People 2030*. Office of Disease Prevention and Health Promotion. Retrieved from https://health.gov/healthypeople/objectives-and-data/browse-objectives/mental-health-and-mental-disorders

financial worries, leaving little time or energy to focus on their health. Lack of access to healthy foods, safe places to exercise, or recreational spaces makes the situation even harder.

Finally, the workforce shortage in behavioral health was mentioned repeatedly. Many professionals have left the field, and those who remain are stretched thin. There is also a need to grow a more culturally competent workforce patients want to be treated by people who understand their background and community.

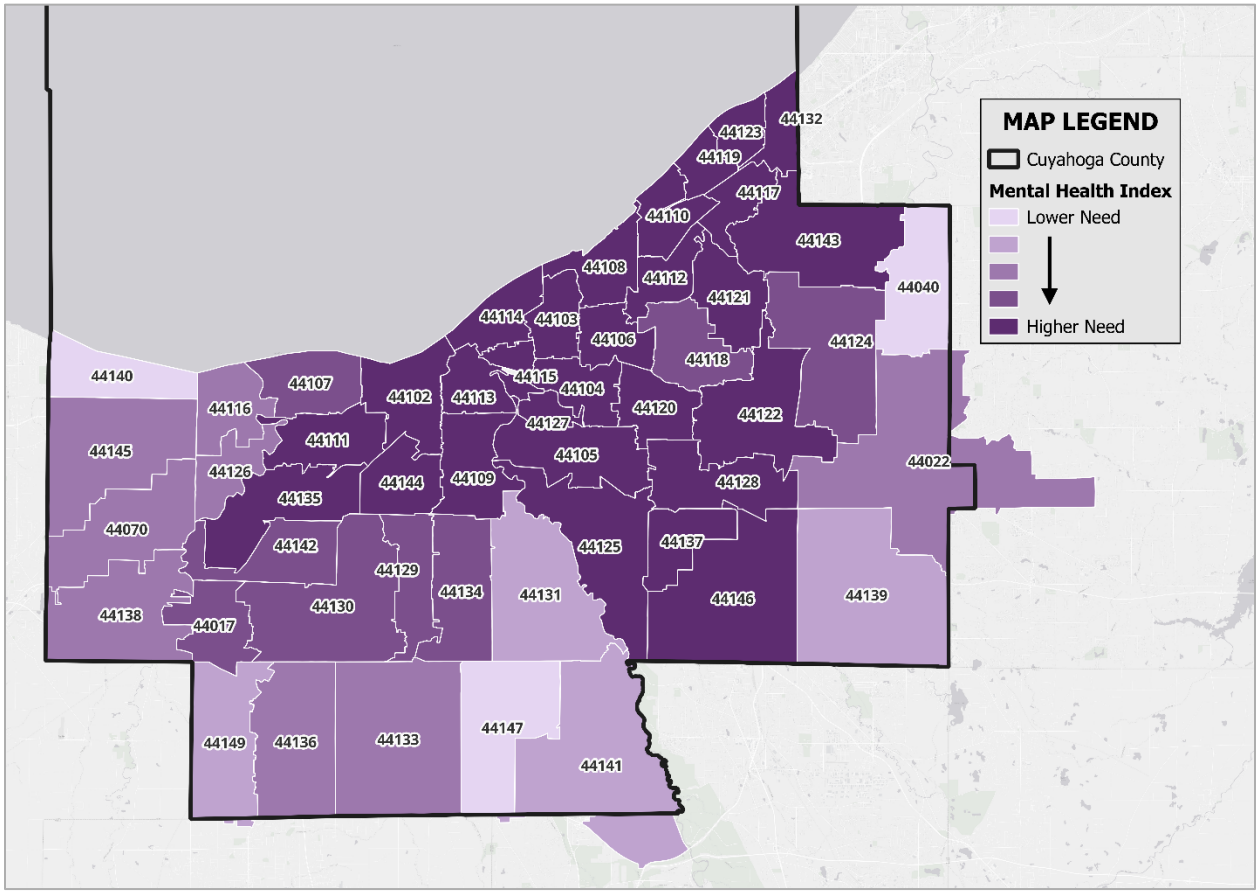
Secondary Data Findings

The topic *Mental Health and Mental Disorders* ranked as the 12th highest scoring health topic in Cuyahoga County, with a score of 1.39. See Appendix A for a full table of indicators scored within this topic area. The following are indicators of concern, which scored at or above 1.50:

- Poor Mental Health: Average Number of Days
- Self-Reported General Health Assessment: Good or Better
- Poor Mental Health: 14+ Days
- Adults who Feel Life is Slipping Out of Control

Conduent's Mental Health Index (MHI) can help to estimate which regions of Cuyahoga County are more likely to experience poor mental health outcomes. The MHI uses socioeconomic data to estimate which zip codes are at greatest risk for poor mental health, on a standardized scale that ranges from 0 to 100. Each zip code is also locally ranked, as seen in Figure 39, based on its index value to identify relative levels of need across the county. Darker shades of purple indicate greater levels of need. The zip codes in Cuyahoga with the highest index values are 44104 with an index value of 100.0, followed by zip codes 44103, 44108, and 44112, each with an index value of 99.9. See Appendix A for a full table of index values.

FIGURE 39: MENTAL HEALTH INDEX



The following maps generated using Electronic Health Record (EHR) data sourced from University Hospitals and census data may also help to identify where mental health challenges are most concerning across the county.

FIGURE 40: ESTIMATED RATE OF DEPRESSION AMONG ALL INDIVIDUALS IN CUYAHOGA COUNTY BY ZIP CODE

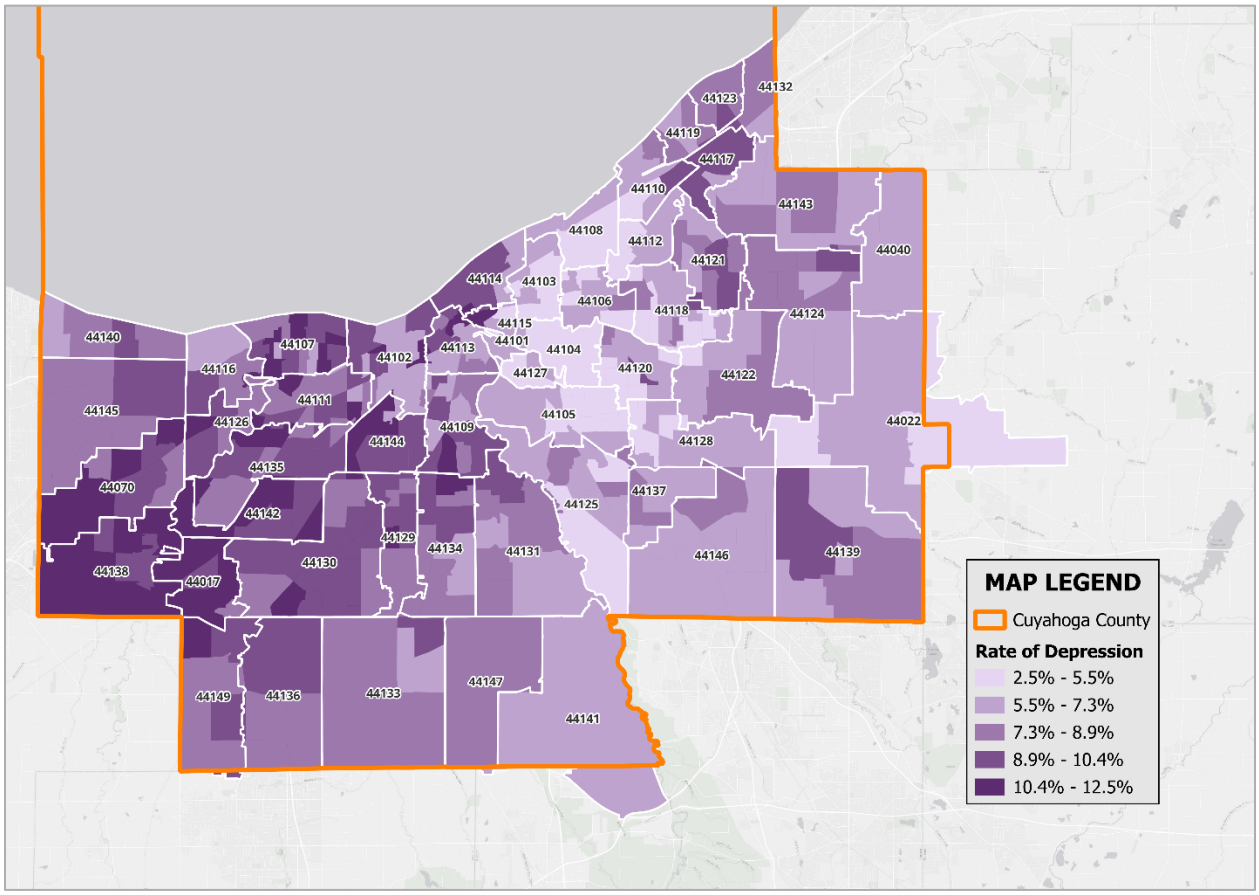
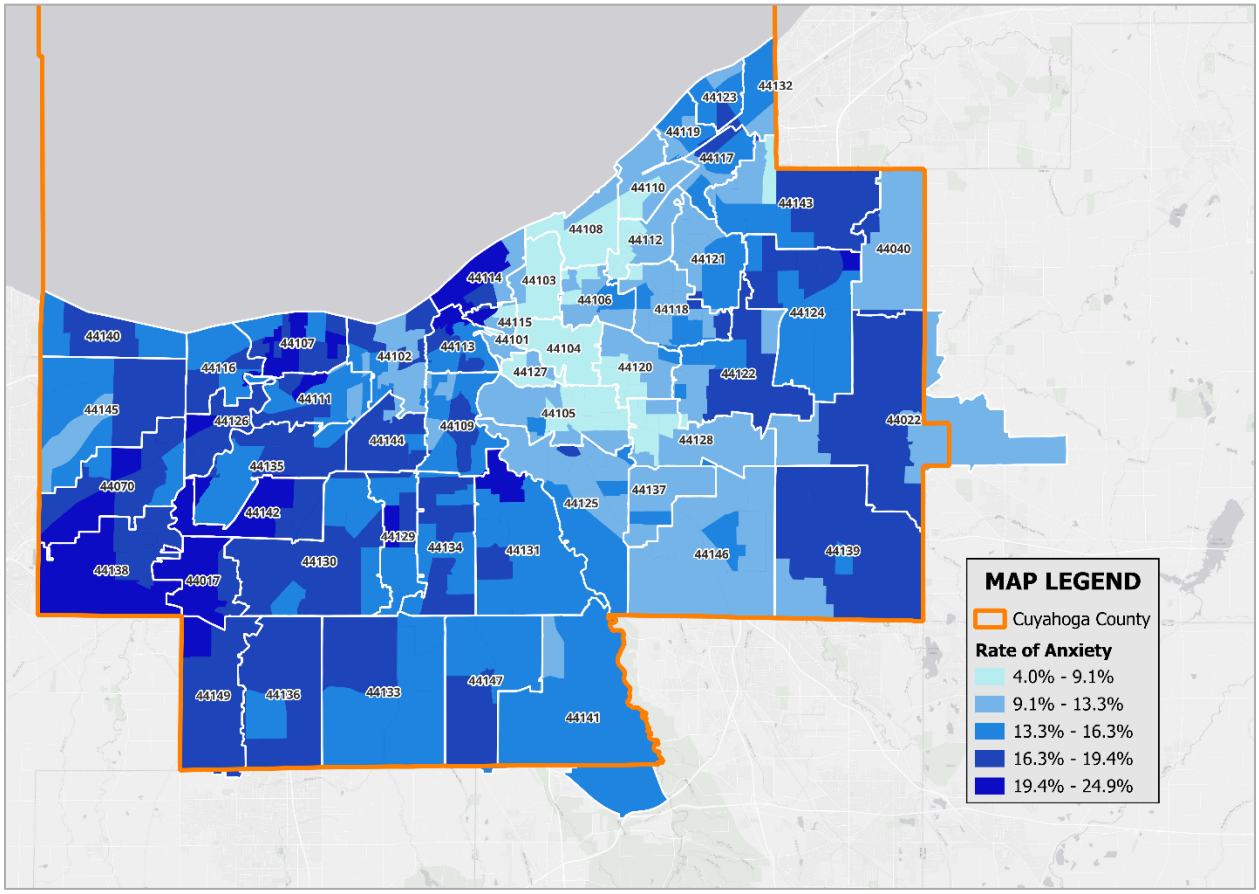


FIGURE 41: ESTIMATED RATE OF ANXIETY AMONG ALL INDIVIDUALS IN CUYAHOGA COUNTY BY ZIP CODE



Substance Use

Substance use includes the harmful or risky use of alcohol, tobacco, and drugs. It can lead to serious health problems, including addiction, overdose, and death. *Healthy People 2030* aims to reduce substance use and related harm by increasing access to treatment, supporting prevention, and promoting healthier choices. This goal includes efforts to reduce overdose deaths and make recovery services more available and welcoming.[24]

Primary Data Findings

Key informants identified substance use as a major and evolving public health crisis in the region. Interviewees shared that opioid addiction continues to harm many individuals and families, especially as fentanyl and other synthetic drugs become more common in street drug supplies. These substances often lead to accidental overdoses, even among people who may not realize what they are taking. Harm reduction services such as fentanyl test strips and naloxone (a life-saving drug that reverses opioid overdoses) were highlighted as important tools to keep people alive long enough to seek recovery.

Substance use is strongly linked to mental health challenges and stress from poverty, trauma, and housing instability. Informants said that substance use disorders should be treated like any other health condition, such as diabetes or heart disease. Many people use substances to cope with long-term pain or trauma, and treating these issues with compassion and support is essential for recovery. Reducing stigma is also key to people feeling safe asking for help without fear of judgment.

Access to services remains a challenge. Although Cuyahoga County has many providers, interviewees said the system is stretched thin. The number of organizations creates complexity, and funding is often spread too thin across many programs. Some residents still do not know where to go for help or struggle to navigate a complex system of care. Transportation, lack of insurance, and culturally appropriate care were also mentioned as barriers to treatment, especially in underserved communities.

[24] U.S. Department of Health and Human Services. (n.d.). *Substance use - Healthy People 2030*. Office of Disease Prevention and Health Promotion. Retrieved from https://health.gov/healthypeople/objectives-and-data/browse-objectives/substance-use

Interviewees emphasized that education and prevention must begin early, especially with young people. There is confusion around marijuana laws, vaping, and other substances that appear "less harmful." These changing norms can influence youth behavior, leading to greater risk of long-term substance use. Schools, community centers, and trusted leaders were seen as vital places to educate and support youth before problems began.

While the community has made progress in reducing stigma and increasing awareness, interviewees stressed the importance of continuing to invest in prevention, harm reduction, and treatment services to build a healthier future.

Secondary Data Findings

The topic *Alcohol and Drug Use* ranked as the 7th highest scoring health topic in Cuyahoga County, with a score of 1.57. See Appendix A for a full table of indicators scored within this topic area. The following are indicators of concern, which scored at or above 1.50:

- Alcohol-Impaired Driving Deaths
- Death Rate due to Drug Poisoning
- Age-Adjusted Drug and Opioid-Involved Overdose Death Rate
- Adults who Binge Drink

Sexually Transmitted Infections

Sexually transmitted infections (STIs) are common and can lead to serious health problems if not treated. STIs like chlamydia, gonorrhea, syphilis, and HIV can spread through sexual contact, and many people don't have symptoms at first. *Healthy People 2030* focuses on preventing the spread of STIs by increasing education, testing, and access to care. It also emphasizes reducing the stigma and improving services for people most affected by these infections.[25]

Primary Data Findings

Key informants shared that STIs are a growing concern, especially among youth and communities of color. Interviewees noted that young people are becoming sexually active at earlier ages, yet many are not receiving education or services to help them stay safe. Some youth are unaware of the basic facts, like the existence of female condoms, or where to get tested confidentially. There is a strong need for more sexual health education, especially in schools and trusted community spaces like community organizations or cultural centers.

A major issue is lack of access to services. Informants reported that some STI clinics have closed, making it harder for young people to find testing or treatment. Additionally, many young people do not tell their parents when they experience symptoms or need care, which makes confidential, teen-friendly services even more important. For immigrant and Latino communities, trust, language barriers, and immigration status were also seen as obstacles to getting tested or treated.

Participants emphasized the importance of meeting people where they are—offering resources like condoms and STI information at schools, churches, and community events. They also called for more outreach through social media and culturally tailored education tools, like short videos in Spanish or youth-friendly formats. Some mentioned that older youth and parents alike would benefit from sessions that help break down taboos and provide practical knowledge.

Community partners suggested that services should be expanded to include not only treatment but also prevention tools like condom distribution, accessible testing sites,

[25] U.S. Department of Health and Human Services. (n.d.). *Sexually transmitted infections - Healthy People 2030*. Office of Disease Prevention and Health Promotion. Retrieved from https://health.gov/healthypeople/objectives-and-data/browse-objectives/sexually-transmitted-infections

and peer educators. Including parents in the conversation was also seen as helpful, as many adults also lack current information or feel uncomfortable talking about sexual health with their children.

Secondary Data Findings

The topic *Sexually Transmitted Infections* ranked as the 2nd highest scoring health topic in Cuyahoga County, with a score of 1.89. Notably, all indicators scored that were available to score this topic area scored above 1.50, and were thus, indicators of concern. These indicators are included in Table 9 below. More details can be found in Appendix A.

TABLE 9: DATA SCORING RESULTS FOR SEXUALLY TRANSMITTED INFECTIONS

Score	Health Indicator	Units	Cuyahoga County	HP2030	OH	U.S.	OH Counties	U.S. Counties	Trend
2.18	Syphilis Incidence Rate	*cases/ 100,000 population*	21.4	-	16.4	-		-	
1.91	Age-Adjusted Death Rate due to HIV	*deaths/ 100,000 population*	1.5	-	0.9	-	-	-	
1.88	Chlamydia Incidence Rate	*cases/ 100,000 population*	779.4	-	464.2	-		-	
1.59	Gonorrhea Incidence Rate	*cases/ 100,000 population*	334.3	-	168.8	-		-	

Other Findings Impacting Health

Critical components in assessing the needs of a community are identifying barriers to accessing health care. Additionally, the identification of barriers will help inform and focus on strategies for addressing the prioritized health needs of University Hospitals (UH). The following section identifies barriers as they pertain to Cuyahoga County.

Poverty

Poverty is a major issue. Informants said that high living costs and low wages are making life harder since the pandemic. One person shared, ***"Everything is so expensive—you cannot afford to live. That's contributing to a lot of problems."*** People are often forced to choose between paying bills, buying food, or getting medical care. These financial stressors lead to mental health struggles and poor physical health. Even when health care is available, many can't access it due to transportation or insurance issues.

Education

Education and employment are also big factors. When young people don't graduate from high school or can't find jobs, they are less likely to have insurance or a steady income. This limits their ability to get health services. Job training, college access, and trade school programs were suggested as ways to improve the community's health and future.

> *Unemployment keeps people from having insurance or funds to pay for support.*

Transportation

Transportation is another barrier. Not everyone has a car, and public transit doesn't always reach health centers or grocery stores. Interviewees shared how important it is for services to be closer to where people live. One example mentioned were mobile vans for health screenings or bringing fresh produce to neighborhoods that don't have full-service grocery stores.

Insurance

Community feedback showed that getting health insurance is closely tied to having a job, transportation, and knowing how to use the health system. Some residents shared that **"the unemployment rates prevent people from having access to things like insurance or funds to be able to pay for assistance and support."** Even with insurance, it can still be hard to get care if providers do not take certain plans, especially Medicaid. As one person said, *"insurance companies choose what they want to cover and what they don't,"* which can make preventive care harder to get. Language barriers, cultural differences, and lack of transportation also keep people from using their benefits. As one key informant explained, *"just because you expand Medicaid doesn't mean that people have access to providers."* These concerns show the need for affordable insurance, more doctors who accept different plans, and better outreach so people can actually use the coverage they have.

Finally, community connection and hope were described as both challenges and strengths. Some residents feel isolated or forgotten, especially in areas with boarded-up buildings or poor infrastructure. This sends a message that their lives don't matter. But others pointed to the resilience of the community, saying, ***"There's so much hope and joy and resilience that we don't celebrate enough."*** Investing in neighborhoods, supporting local leaders, and giving people a voice in decisions were seen as powerful ways to improve health and well-being.

Conclusions

This Community Health Needs Assessment (CHNA), conducted for University Hospitals (UH), used a comprehensive set of secondary and primary data to determine the ten significant health needs in Cuyahoga County. The prioritization process identified three top health needs: Chronic Disease Maternal and Child Health, and Wellbeing.

The findings in this report will be used to guide the development of the UH Implementation Strategy (IS) for the following hospitals. The IS will outline targeted approaches to address identified priorities and improve the health of the community these hospitals serve:

- UH Ahuja Medical Center
- Beachwood RH, LLC (UH Rehabilitation Hospital)
- UH Beachwood Medical Center
- UH Cleveland Medical Center
- UH Parma Medical Center
- UH Rainbow Babies & Children's Hospital
- UH St. John Medical Center

University Hospitals

Appendices

Appendix A: Secondary Data (Methodology and Data Scoring Tables)

Secondary Data Sources

Secondary data used for this assessment were collected and analyzed from the Healthy Northeast Ohio (NEO) community data platform. Healthy NEO is a publicly available website which houses neutral population health data and community health resources to support community health improvement efforts across a 9-county region. The data on this platform, maintained by researchers and analysts at Conduent HCI, includes over 400 community indicators, spanning at least 24 topics in the areas of health, determinants of health, and quality of life. The data are primarily derived from state and national public secondary data sources. The value for each of these indicators is compared to other communities, national targets, and to previous time periods. The following is a list of secondary sources used in Cuyahoga County's Community Health 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 Department of Health, Infectious Diseases
- Ohio Department of Health, Vital Statistics
- Ohio Department 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
- Purdue Center for Regional Development
- The Ohio Pregnancy Assessment Survey (OPAS) Dashboard
- U.S. Bureau of Labor Statistics

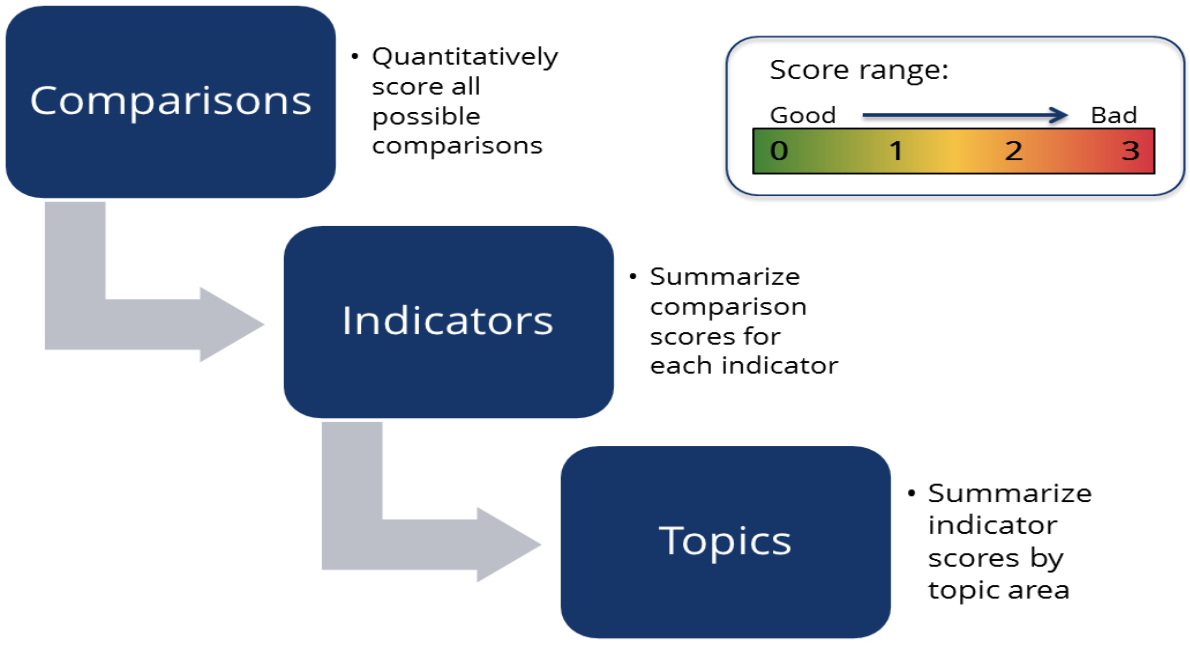
- U.S. Census - County Business Patterns
- U.S. Census Bureau - Small Area Health Insurance Estimates
- U.S. Environmental Protection Agency
- United For ALICE

Data Scoring

Scoring Overview

HCI's Data Scoring Tool was used to systematically summarize multiple comparisons in order to rank indicators based on the 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 42). 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 42: SUMMARY OF TOPIC SCORING ANALYSIS



Comparison to Values: State, National, and Targets

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

Comparison to a Distribution of County Values: State and Nation

For each indicator with available data, 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. For ease of interpretation and analysis, the indicator tables included in the body of this report visually represent this distribution data as a green-yellow-red gauge. This gauge illustrates how the county fares against a distribution of counties across either the state or across the nation. Counties within the most concerning quartile of scores are "in the red," those within the second most concerning quartile of scores are "in the yellow," and those within the two least concerning quartiles are "in the green." See also Table 9.

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. See Table 9 for a guide to interpreting trend data presented in this report.

TABLE 9: ICON LEGEND

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

Missing Values

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

Indicator Scoring

Indicator scores are calculated as a weighted average of all included comparison scores. If none of the included comparison types are possible for an indicator, no score is calculated, and the indicator is excluded from the data's scoring results.

Topic Scoring

Indicator scores are averaged by topic area to calculate topic scores. Each indicator may be included in up to three topics: 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.

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 10 for a full list of index values for each zip code in Cuyahoga County.

TABLE 10: COMMUNITY HEALTH INDEX, FOOD INSECURITY INDEX, AND MENTAL HEALTH INDEX VALUES FOR CUYAHOGA COUNTY ZIP CODES

Zip Code	CHI Value	FII Value	MHI Value	Zip Code	CHI Value	FII Value	MHI Value
44017	43.3	50.0	72.1	**44124**	14.7	29.0	77.7
44022	6.8	14.5	66.4	**44125**	72.3	91.2	94.8
44040	4.9	0.3	25.7	**44126**	33.8	42.7	66.6
44070	38.2	40.6	62.9	**44127**	99.1	98.4	98.3
44102	95.9	96.4	98.5	**44128**	86.9	97.2	99.7
44103	98.4	98.6	99.9	**44129**	46.1	55.7	80.8
44104	99.8	100.0	100.0	**44130**	50.5	54.0	82.6
44105	96.5	97.7	99.7	**44131**	23.6	13.2	42.0
44106	83.7	82.6	97.6	**44132**	66.2	95.6	97.1
44107	41.2	49.4	77.2	**44133**	13.1	33.5	58.5
44108	96.6	98.0	99.9	**44134**	58.6	52.0	86.1
44109	94.5	93.8	97.9	**44135**	90.7	92.0	97.4
44110	95.0	99.0	99.7	**44136**	20.0	14.4	59.4
44111	86.9	90.5	94.6	**44137**	72.9	91.2	97.4
44112	93.9	97.0	99.9	**44138**	12.7	5.4	50.9
44113	82.0	84.1	91.7	**44139**	4.7	12.4	34.5
44114	91.2	62.1	96.3	**44140**	8.5	10.2	19.4
44115	99.9	99.9	99.6	**44141**	28.2	2.9	40.5
44116	7.8	12.9	55.2	**44142**	72.6	48.3	84.7
44117	23.4	89.1	99.5	**44143**	19.6	33.0	93.7
44118	31.9	62.9	88.6	**44144**	77.3	83.6	93.2
44119	78.8	92.5	97.2	**44145**	14.8	15.8	64.4
44120	57.1	87.9	98.7	**44146**	25.3	71.7	97.2
44121	22.1	79.4	90.9	**44147**	3.6	19.6	25.5
44122	13.3	35.0	90.6	**44149**	13.8	10.0	35.8
44123	55.6	91.9	97.1				

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 (formerly Health Equity 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 socioeconomic needs correlated with preventable hospitalizations and premature death.

What do the ranks and colors mean?

Ranks and colors help to identify the relative level of need within a community or service area. The national index value for each location is compared to all other similar locations within the community area to assign a relative rank (from 1 to 5) locally. These ranks are used to color the map and chart for the CHI, with darker colors 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 colors 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 availability varies by health topic. Some topics contain a robust set of secondary data indicators, while others may have a limited number of indicators, or limited subpopulations covered by those specific indicators.

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

Race or Ethnic and Special Population Groupings

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

Zip Codes and Zip Code Tabulation Areas

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

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

Topic Scores

Results from the secondary data topic scoring can be seen in Tables 11 and 12 below. The highest scoring health need in Cuyahoga County was Sexually Transmitted Infections with a score of 2.04.

TABLE 11: HEALTH TOPIC SCORES: CUYAHOGA COUNTY

Health Topic	Score
Other Chronic Conditions	1.92
Sexually Transmitted Infections	1.89
Prevention & Safety	1.72
Older Adults	1.67
Children's Health	1.65
Wellness & Lifestyle	1.64
Alcohol & Drug Use	1.57
Maternal, Fetal & Infant Health	1.51
Weight Status	1.46
Diabetes	1.41
Nutrition & Healthy Eating	1.40
Mental Health & Mental Disorders	1.39
Cancer	1.38
Respiratory Diseases	1.31
Heart Disease & Stroke	1.27
Health Care Access & Quality	1.24
Immunizations & Infectious Diseases	1.22
Women's Health	1.17
Oral Health	1.16
Tobacco Use	1.03
Physical Activity	0.82

TABLE 12: QUALITY OF LIFE TOPIC SCORES: CUYAHOGA COUNTY

Quality of Life Topic	Score
Economy	1.82
Education	1.72
Community	1.57
Environmental Health	1.46

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 13 below as a reference key for indicator data sources.

TABLE 13: 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	Purdue Center for Regional Development
24	The Ohio Pregnancy Assessment Survey (OPAS) Dashboard
25	U.S. Bureau of Labor Statistics
26	U.S. Census - County Business Patterns
27	U.S. Census Bureau - Small Area Health Insurance Estimates
28	U.S. Environmental Protection Agency
29	United For ALICE

***ALCOHOL & DRUG USE**: These indicators describe drug and alcohol use and treatment for people with substance use disorders.*

Score	Indicator	Units	Cuyahoga County	HP2030	OH	U.S.	Measurement Period	Source
2.56	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	41.1	-	32.2	26.3	*2017-2021*	10
2.21	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	43.2	20.7	42.2	27.2	*2019-2021*	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
1.76	Adults who Binge Drink	*percent*	18.1	-		16.6	*2022*	5
1.00	Adults who Drink Excessively	*percent*	17.1	-	20.0	18.1	*2021*	10
0.82	Liquor Store Density	*stores/ 100,000 population*	6.1	-	5.6	10.9	*2022*	26
0.62	Mothers who Smoked During Pregnancy	*percent*	3.8	4.3	7.9	3.7	*2022*	18

***CANCER**: These indicators focus on cancer screening, prevention, incidence, and mortality.*

Score	Indicator	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
2.35	Cancer: Medicare Population	*percent*	13.0	-	12.0	12.0	*2022*	7
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
2.00	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
0.65	Mammography Screening: Medicare Population	*percent*	50.0	-	49.0	47.0	*2022*	7

***CHILDREN'S HEALTH**: These indicators focus on children's health, safety, and well-being.*

Score	Indicator	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*	4611	-	-	-	*2021*	11
1.65	Designated Ohio Healthy Programs (Count)	*programs*	73	-	-	-	*2021*	11
1.65	Families Served by Designated Ohio Healthy Programs (Count)	*families*	2423	-	-	-	*2021*	11
1.65	Family Engagement Activities Supported by Designated Ohio Healthy Programs (Count)	*activities*	2640	-	-	-	*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*	1056	-	-	-	*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

***COMMUNITY**: These indicators focus on ways organizations, businesses, schools, and residents can help build safe and healthy communities.*

Score	Indicator	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	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	41.1	-	32.2	26.3	*2017-2021*	10
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
2.41	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

2.35	Social Associations	*membership associations/ 10,000 population*	9.0	-	10.7	9.1	*2021*	10
2.24	Residential Segregation - Black/White	*Score*	71.5	-	69.5	62.7	*2024*	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*	1005	-	988	1348	*2019-2023*	2
2.12	Mortgaged Owners Median Monthly Household Costs	*dollars*	1529	-	1472	1902	*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*	85788	-	-	-	*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*	62823	-	69680	78538	*2019-2023*	2
1.41	Substantiated Child Abuse Rate	*cases/ 1,000 children*	9.3	8.7	6.9	-	*2021*	4
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*	26
1.09	Persons with Health Insurance	*percent*	93.0	92.4	92.9	-	*2022*	27
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*	23
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*	23
0.71	Solo Drivers with a Long Commute	*percent*	31.3	-	30.6	36.4	*2018-2022*	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*	41559	-	39455	43289	*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*	23
0.44	Death Rate due to Motor Vehicle Collisions	*deaths/ 100,000 population*	8.4	-	10.9	12.0	*2015-2021*	10
0.18	People 25+ with a Bachelor's Degree or Higher	*percent*	35.9	-	30.9	35.0	*2019-2023*	2

***DIABETES**: These indicators focus on diabetes cases, complications, and deaths.*

Score	Indicator	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
0.82	Diabetes: Medicare Population	*percent*	23.0	-	25.0	24.0	*2022*	7

***ECONOMY**: These indicators focus on economic opportunity, cost of living, and employment for all community populations.*

Score	Indicator	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
2.24	Residential Segregation - Black/White	*Score*	71.5	-	69.5	62.7	*2024*	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*	1005	-	988	1348	*2019-2023*	2
2.12	Mortgaged Owners Median Monthly Household Costs	*dollars*	1529	-	1472	1902	*2019-2023*	2
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*	28068	-	-	-	*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 Living Below Poverty Level	*percent*	16.3	-	13.0	-	*2021*	29
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
1.79	People Living Below 200% of Poverty Level	*percent*	32.2	-	29.6	28.2	*2023*	1
1.76	Severe Housing Problems	*percent*	15.9	-	12.8	16.7	*2016-2020*	10
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	Size of Labor Force	*persons*	616132	-	-	-	*October 2024*	25
1.59	Households with Student Loan Debt	*percent*	9.4	-	9.1	9.8	*2024*	8
1.59	Median Household Income	*dollars*	62823	-	69680	78538	*2019-2023*	2
1.53	Households that are Above the Asset Limited, Income Constrained, Employed (ALICE) Threshold	*percent*	58.3	-	62.0	-	*2021*	29
1.50	Adults who Feel Overwhelmed by Financial Burdens	*percent*	34.2	-	34.0	33.6	*2024*	8
1.35	Households that are Asset Limited, Income Constrained, Employed (ALICE)	*percent*	25.3	-	25.0	-	*2021*	29
1.35	Households with a 401k Plan	*percent*	37.4	-	38.4	40.8	*2024*	8
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*	48911	-	51608	57108	*2019-2023*	2
1.18	Total Employment Change	*percent*	5.0	-	2.9	5.8	*2021-2022*	26
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*	41559	-	39455	43289	*2019-2023*	2
0.47	Overcrowded Households	*percent*	1.1	-	1.4	3.4	*2019-2023*	2
0.00	Students Eligible for the Free Lunch Program	*percent*	11.6	-	19.1	42.8	*2022-2023*	14
0.00	Unemployed Workers in Civilian Labor Force	*percent*	2.8	-	3.5	3.9	*October 2024*	25

***EDUCATION**: These indicators focus on educational outcomes and access to high-quality, affordable education for both K-12 and higher education.*

Score	Indicator	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	Vocational, Technical, and Other School Tuition Spending-to-Income Ratio	*percent*	1.8	-	1.6	1.6	*2024*	9
2.18	Student-to-Teacher Ratio	*students/ teacher*	17.3	-	16.4	15.4	*2022-2023*	14
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*	4611	-	-	-	*2021*	11
1.65	Designated Ohio Healthy Programs (Count)	*programs*	73	-	-	-	*2021*	11

1.65	Families Served by Designated Ohio Healthy Programs (Count)	*families*	2423	-	-	-	*2021*	11
1.65	Family Engagement Activities Supported by Designated Ohio Healthy Programs (Count)	*activities*	2640	-	-	-	*2021*	11
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

***ENVIRONMENTAL HEALTH**: These indicators focus on the population's exposure to harmful pollutants in air, water, soil, food, and materials in home and workplaces.*

Score	Indicator	Units	Cuyahoga County	HP2030	OH	U.S.	Measurement Period	Source
2.41	Air Pollution due to Particulate Matter	*micrograms per cubic meter*	10.9	-	8.9	7.4	*2019*	10
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	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	Asthma: Medicare Population	*percent*	7.0	-	6.0	7.0	*2022*	7
2.00	Daily Dose of UV Irradiance	*Joule per square meter*	3533.0	-	3384.0	-	*2020*	15
1.76	Annual Ozone Air Quality	*grade*	F	-	-	-	*2020-2022*	3
1.76	Severe Housing Problems	*percent*	15.9	-	12.8	16.7	*2016-2020*	10
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*	2.0	-	-	-	*2021*	15
1.62	Blood Lead Levels in Children (>=10 micrograms per deciliter)	*percent*	1.6	-	0.6	-	*2021*	19
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*	1056	-	-	-	*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*	28
1.32	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	5.5	-	2.0	-	*2021*	19
0.82	Food Environment Index		7.8	-	7.0	7.7	*2024*	10
0.82	Liquor Store Density	*stores/ 100,000 population*	6.1	-	5.6	10.9	*2022*	26
0.79	Digital Divide Index	*DDI Score*	19.4	-	40.1	50.0	*2022*	23
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	Access to Exercise Opportunities	*percent*	97.8	-	83.9	84.1	*2024*	10
0.44	Broadband Quality Score	*BQS Score*	69.9	-	53.4	50.0	*2022*	23

HEALTH CARE ACCESS & QUALITY: *These indicators focus on people's access to timely, high-quality health care services.*

Score	Indicator	Units	Cuyahoga County	HP2030	OH	U.S.	Measurement Period	Source
2.41	Preventable Hospital Stays: Medicare Population	*discharges/ 100,000 Medicare enrollees*	3555.0	-	3044.0	2677.0	*2022*	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
1.38	Children with Health Insurance	*percent*	96.4	-	95.1	94.6	*2023*	1
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*	27
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
0.00	Mental Health Provider Rate	*providers/ 100,000 population*	480.6	-	326.1	313.9	*2023*	10
0.00	Non-Physician Primary Care Provider Rate	*providers/ 100,000 population*	235.9	-	140.0	131.4	*2023*	10

***HEART DISEASE & STROKE**: These indicators focus on prevention, treatment, incidence, and mortality related to heart disease and stroke.*

Score	Indicator	Units	Cuyahoga County	HP2030	OH	U.S.	Measurement Period	Source
2.00	Stroke: Medicare Population	*percent*	6.0	-	5.0	6.0	*2022*	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
1.47	Hyperlipidemia: Medicare Population	*percent*	64.0	-	66.0	65.0	*2022*	7
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
1.35	Heart Failure: Medicare Population	*percent*	12.0	-	12.0	11.0	*2022*	7
1.29	Hypertension: Medicare Population	*percent*	66.0	-	67.0	65.0	*2022*	7
1.12	Atrial Fibrillation: Medicare Population	*percent*	14.0	-	15.0	14.0	*2022*	7
1.06	Cholesterol Test History	*percent*	86.1	-	-	86.4	*2021*	5

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
0.82	Ischemic Heart Disease: Medicare Population	*percent*	20.0	-	22.0	21.0	*2022*	7
0.56	Age-Adjusted Death Rate due to Heart Attack	*deaths/ 100,000 population 35+ years*	42.7	-	60.9	-	*2021*	15

***IMMUNIZATIONS & INFECTIOUS DISEASES**: These indicators focus on prevention, treatment, incidence, and mortality related to infectious disease.*

Score	Indicator	Units	Cuyahoga County	HP2030	OH	U.S.	Measurement Period	Source
2.18	Syphilis Incidence Rate	*cases/ 100,000 population*	21.4	-	16.4	-	*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
1.88	Chlamydia Incidence Rate	*cases/ 100,000 population*	779.4	-	464.2	-	*2023*	17
1.59	Gonorrhea Incidence Rate	*cases/ 100,000 population*	334.3	-	168.8	-	*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
0.59	Pneumonia Vaccinations: Medicare Population	*percent*	10.0	-	8.0	8.0	*2022*	7
0.47	Flu Vaccinations: Medicare Population	*percent*	57.0	-	53.0	50.0	*2022*	7
0.47	Overcrowded Households	*percent*	1.1	-	1.4	3.4	*2019-2023*	2

***MATERNAL, FETAL, & INFANT HEALTH**: These indicators focus on health and safety of infants and their birthing parents.*

Score	Indicator	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*	24
1.91	Pre-Pregnancy Diabetes	*percent*	4.8	-	4.2	-	*2022*	24
1.91	Stopped Breastfeeding Due to Resuming Work	*percent*	26.6	-	17.5	-	*2022*	24
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*	24
1.74	Chronic Health Condition(s) During Pregnancy	*percent*	50.6	-	49.6	-	*2022*	24
1.74	Postpartum Depression	*percent*	16.4	-	16.3	-	*2022*	24
1.74	Pre-Pregnancy Hypertension	*percent*	7.6	-	7.0	-	*2022*	24
1.56	Gestational Diabetes	*percent*	10.3	-	10.6	-	*2022*	24
1.44	Prevalence of Unintended Pregnancy	*percent*	22.4	-	21.1	-	*2022*	24

1.38	Pre-Pregnancy Depression	*percent*	19.9	-	22.5	-	*2022*	24
1.38	Pre-Pregnancy E-Cigarette Use	*percent*	6.8	-	8.6	-	*2022*	24
1.26	Breastfeeding at 8 Weeks	*percent*	73.7	-	70.9	-	*2022*	24
1.26	Infant Sleeps on Back	*percent*	87.0	-	86.2	-	*2022*	24
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*	24
1.15	Prevalence of Intended Pregnancy	*percent*	60.7	-	61.0	-	*2022*	24
1.09	Gestational Depression	*percent*	18.9	-	21.7	-	*2022*	24
0.97	Infant Sleeps Alone on Recommended Surface	*percent*	51.5	-	51.4	-	*2022*	24
0.97	Infant Sleeps in Crib, Bassinet, or Play Yard	*percent*	93.9	-	93.9	-	*2022*	24
0.97	Infant Sleeps Without Objects in Bed	*percent*	70.1	-	68.7	-	*2022*	24
0.79	Pre-Pregnancy Smoking	*percent*	10.2	-	12.2	-	*2022*	24
0.62	Mothers who Smoked During Pregnancy	*percent*	3.8	4.3	7.9	3.7	*2022*	18

***MENTAL HEALTH & MENTAL DISORDERS**: These indicators focus on psychological well-being and mental health conditions.*

Score	Indicator	Units	Cuyahoga County	HP2030	OH	U.S.	Measurement Period	Source
2.53	Poor Mental Health: Average Number of Days	*days*	5.8	-	5.5	4.8	*2021*	10
2.29	Self-Reported General Health Assessment: Good or Better	*percent*	84.2	-	85.4	86.0	*2024*	8
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
1.29	Depression: Medicare Population	*percent*	16.0	-	17.0	16.0	*2022*	7
1.18	Alzheimer's Disease or Dementia: Medicare Population	*percent*	6.0	-	6.0	6.0	*2022*	7
1.12	Age-Adjusted Death Rate due to Alzheimer's Disease	*deaths/ 100,000 population*	22.6	-	33.8	-	*2020-2022*	21
1.00	Age-Adjusted Death Rate due to Suicide	*deaths/ 100,000 population*	13.5	12.8	14.5	-	*2020-2022*	21
0.00	Mental Health Provider Rate	*providers/ 100,000 population*	480.6		326.1	313.9	*2023*	10

***NUTRITION & HEALTHY EATING**: These indicators focus on people's access to and consumption of healthy, affordable food options.*

Score	Indicator	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
1.76	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	*Percent*	39.6	-	38.1	38.2	*2024*	8
0.82	Food Environment Index		7.8	-	7.0	7.7	*2024*	10
0.79	Adults who Drank Soft Drinks: Past 7 Days	*percent*	46.6	-	48.6	47.5	*2024*	8

***OLDER ADULTS**: These indicators focus on the health and well-being of older adults, especially those aged 65 and above, including health conditions that primarily impact this population.*

Score	Indicator	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
2.35	Cancer: Medicare Population	*percent*	13.0	-	12.0	12.0	*2022*	7
2.35	Osteoporosis: Medicare Population	*percent*	12.0	-	11.0	11.0	*2022*	7
2.00	Asthma: Medicare Population	*percent*	7.0	-	6.0	7.0	*2022*	7
2.00	Stroke: Medicare Population	*percent*	6.0	-	5.0	6.0	*2022*	7
1.94	People 65+ Living Alone (Count)	*people*	85788	-	-	-	*2019-2023*	2
1.94	People 65+ Living Below Poverty Level (Count)	*people*	28068	-	-	-	*2019-2023*	2
1.71	Chronic Kidney Disease: Medicare Population	*percent*	19.0	-	18.0	18.0	*2022*	7
1.65	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	37.0	-	38.0	35.0	*2022*	7
1.59	Adults 65+ with Total Tooth Loss	*percent*	13.9	-	-	12.2	*2022*	5
1.47	Hyperlipidemia: Medicare Population	*percent*	64.0	-	66.0	65.0	*2022*	7
1.35	Heart Failure: Medicare Population	*percent*	12.0	-	12.0	11.0	*2022*	7
1.29	Depression: Medicare Population	*percent*	16.0	-	17.0	16.0	*2022*	7
1.29	Hypertension: Medicare Population	*percent*	66.0	-	67.0	65.0	*2022*	7
1.24	Median Household Income: Householders 65+	*dollars*	48911	-	51608	57108	*2019-2023*	2
1.18	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	10.9	-	12.1	-	*2020-2022*	21

1.18	Alzheimer's Disease or Dementia: Medicare Population	*percent*	6.0	-	6.0	6.0	*2022*	7
1.12	Age-Adjusted Death Rate due to Alzheimer's Disease	*deaths/ 100,000 population*	22.6	-	33.8	-	*2020-2022*	21
1.12	Atrial Fibrillation: Medicare Population	*percent*	14.0	-	15.0	14.0	*2022*	7
1.12	COPD: Medicare Population	*percent*	11.0	-	12.0	11.0	*2022*	7
0.82	Diabetes: Medicare Population	*percent*	23.0	-	25.0	24.0	*2022*	7
0.82	Ischemic Heart Disease: Medicare Population	*percent*	20.0	-	22.0	21.0	*2022*	7
0.65	Mammography Screening: Medicare Population	*percent*	50.0	-	49.0	47.0	*2022*	7

***ORAL HEALTH**: These indicators focus on dental care and oral health conditions, including tooth decay.*

Score	Indicator	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

OTHER CHRONIC CONDITIONS: *These indicators focus on chronic conditions not captured under the topics Cancer, Diabetes, and Heart Disease and Stroke (e.g., kidney disease and bone/joint health).*

Score	Indicator	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
2.35	Osteoporosis: Medicare Population	percent	12.0		11.0	11.0	2022	7
1.71	Chronic Kidney Disease: Medicare Population	percent	19.0		18.0	18.0	2022	7
1.65	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	percent	37.0		38.0	35.0	2022	7
1.41	Adults with Arthritis	percent	30.4			26.6	2022	5

PHYSICAL ACTIVITY*: These indicators focus on mobility and physical fitness activities.*

Score	Indicator	Units	Cuyahoga County	HP2030	OH	U.S.	Measurement Period	Source
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 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
0.44	Access to Exercise Opportunities	*percent*	97.8	-	83.9	84.1	*2024*	10

PREVENTION AND SAFETY*: These indicators focus on injuries, both intentional and unintentional, due to incidents such as falls, drug poisonings, and firearm incidents.*

Score	Indicator	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

2.38	Death Rate due to Injuries	*deaths/ 100,000 population*	110.5	-	99.4	80.0	*2017-2021*	10
2.21	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	43.2	20.7	42.2	27.2	*2019-2021*	10
1.76	Severe Housing Problems	*percent*	15.9	-	12.8	16.7	*2016-2020*	10
1.65	Age-Adjusted Death Rate due to Unintentional Poisonings	*deaths/ 100,000 population*	45.2	-	46.5	-	*2020-2022*	21
1.18	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	10.9	-	12.1	-	*2020-2022*	21
0.44	Death Rate due to Motor Vehicle Collisions	*deaths/ 100,000 population*	8.4	-	10.9	12.0	*2015-2021*	10

***RESPIRATORY DISEASES**: These indicators focus on prevention, detection, incidence, and mortality related to respiratory conditions.*

Score	Indicator	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
2.00	Asthma: Medicare Population	*percent*	7.0	-	6.0	7.0	*2022*	7
1.91	Tuberculosis Incidence Rate	*cases/ 100,000 population*	1.9	1.4	1.6	2.9	*2023*	17
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
1.12	COPD: Medicare Population	*percent*	11.0	-	12.0	11.0	*2022*	7
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
0.53	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

***SEXUALLY TRANSMITTED INFECTIONS**: These indicators focus on prevention, detection, incidence, and mortality related to sexually transmitted infectious, including HIV.*

Score	Indicator	Units	Cuyahoga County	HP2030	OH	U.S.	Measurement Period	Source
2.18	Syphilis Incidence Rate	*cases/ 100,000 population*	21.4	-	16.4	-	*2023*	17
1.91	Age-Adjusted Death Rate due to HIV	*deaths/ 100,000 population*	1.5	-	0.9	-	*2020-2022*	21
1.88	Chlamydia Incidence Rate	*cases/ 100,000 population*	779.4	-	464.2	-	*2023*	17
1.59	Gonorrhea Incidence Rate	*cases/ 100,000 population*	334.3	-	168.8	-	*2023*	17

***TOBACCO USE**: These indicators focus on tobacco and e-cigarette use.*

Score	Indicator	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	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
0.74	Tobacco Use: Medicare Population	*percent*	6.0	-	7.0	6.0	*2022*	7
0.29	Adults Who Used Smokeless Tobacco: Past 30 Days	*percent*	1.0	-	1.7	1.6	*2024*	8

***WEIGHT STATUS**: These indicators focus on people's weight status.*

Score	Indicator	Units	Cuyahoga County	HP2030	OH	U.S.	Measurement Period	Source
1.74	Obesity: Medicare Population	*percent*	24.0	-	24.0	19.0	*2022*	7
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

***WELLNESS & LIFESTYLE**: These indicators focus on general healthful behaviors, including adequate sleep and nutrition, as well as general well-being outcomes, such as life expectancy and self-reported general health.*

Score	Indicator	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
2.06	Poor Physical Health: Average Number of Days	*days*	4.0	-	3.6	3.3	*2021*	10
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
1.50	Adults who Feel Life is Slipping Out of Control	*Percent*	24.1	-	24.1	23.9	*2024*	8
1.50	Life Expectancy	*years*	75.7	-	75.6	77.6	*2019-2021*	10
1.32	Adults Happy with Weight	*Percent*	42.2	-	42.1	42.6	*2024*	8
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

***WOMEN'S HEALTH**: These indicators focus on prevention, detection, incidence, and mortality related to conditions that primarily impact women, including breast and cervical cancer.*

Score	Indicator	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
0.65	Mammography Screening: Medicare Population	*percent*	50.0	-	49.0	47.0	*2022*	7

Appendix B: Community Input Assessment Tool

Key Informant Interview Questions

- What community, or geographic area, does your organization serve (or represent)? How does your organization serve the community?
- From your perspective, what does a community need to be healthy?
- What are the top health-related issues that residents are facing in your community that you would change or improve?
- From the health issues and challenges we've just discussed, which do you think are the most difficult to overcome?
- What do you think causes residents to be healthy or unhealthy in your community?
- What could be done to promote health equity? (Health equity 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 we make sure that community voices are heard when decisions are made that affect their community?
- 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?

Appendix C: Community Resources

Appendix D: University Hospitals (UH) Impact Report

This section presents an evaluation of the impact of strategies implemented by University Hospitals facilities located within Cuyahoga County, including:

- UH Ahuja Medical Center
- Beachwood RH, LLC (UH Rehabilitation Hospital)
- UH Cleveland Medical Center
- UH Parma Medical Center
- UH Rainbow Babies & Children's Hospital
- UH St. John Medical Center

Evaluation of Impact

University Hospitals Ahuja Medical Center

University Hospitals Ahuja Medical Center is a 144-bed community-based hospital, located in Beachwood, OH, that provides a wide array of inpatient, outpatient, and emergency services to residents of Cuyahoga, Lake, Summit, and surrounding counties. UH Ahuja Medical Center offers 21 full-service specialties and subspecialties, which include emergency services, cardiology, neurosurgery, pulmonology, orthopedics and more. In 2024, most (62.2%) of University Hospitals Ahuja Medical Center's discharges were residents of Cuyahoga County.

Evaluation of Impact

University Hospitals Ahuja Medical Center Community Health Improvement Efforts

The following evaluation of impact pertains to the actions taken since the last Cuyahoga County CHNA in 2022. The assessment was done jointly between University Hospitals, Cuyahoga County Board of Health, Cleveland Department of Public Health and other community partners and aligns with the State Health Assessment (SHA) and State Health Improvement Plan (SHIP). The 2022 CHNA was adopted by University Hospitals in September of 2022, and the 2023-2025 Implementation Strategy was adopted in March of 2023. This evaluation report covers the period January 2023– December 2024. Outcomes from the 2023-2025 period will be further analyzed in early 2026, in order to include 2025 progress in total, and to further inform prospective 2026 implementation strategies.

Upon review of the 2022 Community Health Needs Assessments, hospital staff for University Hospitals Ahuja Medical Center isolated two top priority community health needs:

1. Community Conditions

2. Accessible and Affordable Healthcare/Behavioral Health

Within these areas, in consideration of the hospital's expertise and its being a community-based hospital, the following objectives were established:

- Increase access to resources for vulnerable populations including under-resourced individuals, youth and infants in Cuyahoga County.
- Improve wellbeing of individuals by increasing access to care by removing identified barriers through health literacy and screenings.
- Reduce the percentage of patients who report they cannot access enough healthy food for themselves or their children & provide additional social support as needed.

- Improve overall health outcomes of patients by integrating resources to address social determinants of health.

Impact

UH Ahuja Medical Center has demonstrated a strong commitment to improving community health through a wide range of outreach, education, and support initiatives. A major focus has been on chronic disease prevention and nutrition education, reaching over 21,000 participants through health talks, screenings, and wellness events. These included blood pressure, glucose, and cholesterol screenings, as well as cooking demonstrations and walking clubs promoting heart health and weight management. The hospital also hosted 34 cooking classes and provided over 20,000 individuals with chronic disease education and support through community events and support groups.

In addressing youth engagement and education, Ahuja hosted or participated in events that reached over 5,400 youth, offering CPR/AED training, nutrition education, and career pathway programs through medical academies, which engaged 185 students. The hospital also provided “Stop the Bleed” training to 410 individuals, enhancing community preparedness for emergencies.

To combat food insecurity, Ahuja partnered with Sodexo to deliver a Summer Lunch Program that served 233 children, and screened 45 individuals for food insecurity, connecting them to community resources. The hospital also launched wellness centers in Bedford and Richmond, which hosted 232 events, served over 3,100 participants, and conducted 1,038 health screenings.

Ahuja’s efforts extended to men’s and women’s health, with 2,525 men and 15,249 women participating in targeted health fairs and educational events. These included screenings, reproductive health education, and wellness resources. The hospital also screened 158 individuals for social determinants of health and referred them to appropriate services.

Overall, UH Ahuja Medical Center’s initiatives reflect a comprehensive, community-centered approach to health equity, prevention, and education, with a strong emphasis on collaboration, accessibility, and measurable impact.

Hospital Staff Interviews

In order to provide a qualitative context regarding University Hospitals Ahuja Medical Centers successes and opportunities for improvement related to the implementation strategies, a discussion guide comprised of four anchor questions was utilized to frame an interview with University Hospitals Ahuja Medical Centers hospital staff on July 1, 2025.

1. What were the most significant successes and strategies in program implementation and community engagement?
2. What strategies experienced barriers to implementation, or were unable to be implemented?
3. How have community partnerships strengthened implementation and community engagement?
4. Are there any opportunities that could potentially be leveraged in the future to improve the community's health?

As a result of this conversation, the following qualitative themes emerged pertaining to University Hospitals Ahuja Medical Center's community health implementation strategy from 2023-2025: 1. Community Conditions, 2. Accessible and Affordable Healthcare/Behavioral Health. The following quotes illustrate these themes:

Community Conditions

UH Ahuja Medical Center has made significant strides in addressing community conditions by increasing access to health education, safety resources, and youth engagement programs. Through partnerships with local schools, libraries, and municipalities, Ahuja hosted or participated in over 230 events, reaching more than 3,100 participants and conducting over 1,000 health screenings. These events included resource fairs, safety education days, and youth-focused programs such as the Medical Academy and Stop the Bleed training, which reached over 400 participants.

Efforts to reduce food insecurity included the Summer Lunch Program, which served 233 children, and monthly cooking classes that promoted healthy eating and chronic disease prevention. Community Health Workers screened 45 individuals for food insecurity and connected them to essential resources. As one team member noted, "Those partnerships are very valuable because one, it helps promote our programming. And every community is different. So, no community is alike. So, we try to tailor our programming as best as we can to fit that community." This tailored, community-centered approach has helped build trust and ensure that services are relevant and impactful.

Accessible and Affordable Healthcare/Behavioral Health

Ahuja Medical Center's commitment to accessible healthcare is reflected in its extensive outreach and education efforts. The center conducted 147 health screening events, reaching over 11,000 individuals, and provided over 20,000 participants with chronic disease education through talks, support groups, and wellness fairs. These included screenings for blood pressure, glucose, and cholesterol, as well as education on heart health, nutrition, and disease management.

The center also hosted 34 cooking demonstrations and provided targeted health education at men's and women's health events, reaching 2,525 men and 15,249 women. Community Health Workers screened 158 individuals for social determinants of health and connected them to appropriate services. One staff member emphasized the impact of this work, saying, "The impact of the screenings, the education has significantly helped individuals along the path of healthier living." Another added, "It helps build trust. We provide them with resources and education and kind of help them navigate the healthcare system when needed."

Despite the success, staff acknowledged the challenges of meeting high demand with limited personnel: "We try to spread the wealth as much as we can, but I think, with the number of requests that can be difficult at times. With spring and summer being the busiest." Still, the team's dedication to outreach and relationship-building continues to drive meaningful health improvements across the community.

Evaluation of Impact

Beachwood RH, LLC (University Hospitals Rehabilitation Hospital, a Joint Venture with Kindred Healthcare)

Beachwood RH, LLC ("UH Rehabilitation Hospital") is a 50-bed, state-of-the-art acute inpatient rehabilitation hospital located in Beachwood, Ohio. UH Rehabilitation Hospital provides acute inpatient medical and functional rehabilitation, as well as treatment and recovery services for individuals who have experienced a variety of conditions including amputation, brain injury, neurological condition, orthopedic injury, spinal cord injury, stroke, and trauma. Outpatient services for individuals with conditions that do not require inpatient rehabilitation care are available at several convenient community locations. In 2021, most (65%) of University Hospitals Rehabilitation Hospital discharges were residents of Cuyahoga County.

Evaluation of Impact

University Hospitals UH Rehabilitation Hospital Community Health Improvement Efforts

The following evaluation of impact pertains to the actions taken since the last Cuyahoga County CHNA in 2022. The assessment was done jointly between University Hospitals Cuyahoga County Board of Health, Cleveland Department of Public Health and other community partners and aligns with the State Health Assessment (SHA) and State Health Improvement Plan (SHIP). The 2022 CHNA was adopted by University Hospitals in September of 2022, and the 2023-2025 Implementation Strategy was adopted in March of 2023. This evaluation report covers the period January 2023– December 2024. Outcomes from the 2023-2025 period will be further analyzed in early 2026, in order to include 2025 progress in total, and to further inform prospective 2026 implementation strategies.

Upon review of the 2022 Community Health Needs Assessments, hospital staff for University Hospitals Rehabilitation Hospital isolated three top priority community health needs:

1. Accessible and Affordable Health Care

Within thisarea, in consideration of the hospital's expertise and its being a community-based hospital, the following objective established:

- Improve wellbeing of adults in Cuyahoga County via disease prevention and management, particularly people with stroke

Impact

UH Rehabilitation Hospital in Beachwood focused its efforts on improving wellness and disease prevention, particularly for individuals recovering from stroke. In 2023, the

hospital hosted 12 community events with a total of 170 participants and conducted monthly stroke support groups to provide ongoing education and emotional support for discharged patients. These sessions featured wellness talks and were designed to help patients adjust to life after hospitalization.

To further promote health literacy, the hospital mailed 1,266 educational flyers throughout the year. These covered topics such as cholesterol management, seasonal health tips, arthritis care, flu prevention, and stress reduction. Additionally, healthy eating and cooking classes were offered quarterly, reaching 14 participants and focusing on nutrition themes like “Fuel for the Future.”

Although the hospital set a goal to screen 250 individuals annually, no screenings were reported in 2023. Plans are in place to improve outreach and participation in 2024, including reintroducing stroke awareness events and expanding community education efforts.

Overall, the hospital’s initiatives reflect a commitment to supporting stroke survivors and promoting chronic disease prevention through education, support groups, and community engagement.

Hospital Leadership Interviews

In order to provide a qualitative context regarding UH Rehabilitation Hospital successes and opportunities for improvement related to the implementation strategies, a discussion guide comprised of four anchor questions was utilized to frame an interview with University Hospitals Lake Health Medical Centers leadership and caregivers on June 9, 2025.

5. What were the most significant successes and strategies in program implementation and community engagement?
6. What strategies experienced barriers to implementation, or were unable to be implemented?
7. How have community partnerships strengthened program implementation and community engagement?
8. Are there any opportunities that could potentially be leveraged in the future to improve the community's health?

As a result of this conversation, the following qualitative themes emerged pertaining to UH Rehabilitation Hospitals community health implementation strategy from 2023-2025: 1. Accessible and Affordable Health Care. The following quotes illustrate these themes:

Accessible and Affordable Health Care

UH Rehabilitation Hospital in Beachwood has focused its community health efforts on improving wellness and disease prevention, particularly for individuals recovering from

stroke. The hospital's primary initiatives include monthly stroke support groups, quarterly healthy eating classes, and educational outreach through direct mailings.

In 2023, the hospital hosted 12 community events with 170 participants and mailed 1,266 health education flyers on topics such as cholesterol, arthritis, flu prevention, and seasonal wellness tips. The stroke support group, held monthly, provided ongoing education and emotional support for discharged patients. As one staff member noted, "One of our strengths in program implementation is our community screenings and stroke support groups. We see a lot of participation, not only from our own patients but also from individuals referred by other hospitals." This expansion aligns with their goal to increase awareness and education around stroke prevention for at least 500 individuals annually.

"There's a great opportunity to leverage national initiatives like World Stroke Day in October to celebrate, raise awareness about strokes, and educate the public on the signs and symptoms. It's a chance to expand our reach and make a bigger impact," said one team member.

The hospital also offers quarterly healthy eating and cooking classes, which reached 14 participants in 2023. While participation was lower than expected, efforts are underway to improve promotion and engagement. "We're working on a plan to improve awareness with current and former patients, along with promotion of healthy eating and cooking classes by medical staff," the team noted.

Overall, UH Rehabilitation Hospital Beachwood is building a strong foundation for community health through education, support, and strategic outreach, with a clear focus on stroke prevention and recovery.

Evaluation of Impact

University Hospitals Cleveland Medical Center

UH Cleveland Medical Center is a 1,032 bed, academic medical center and an affiliate of Case Western Reserve University. It is located on a 35-acre campus in the University Circle neighborhood of Cleveland, OH which includes University Hospitals Rainbow Babies & Children's Hospital and University Hospitals Seidman Cancer Center. UH Cleveland Medical Center provides comprehensive medical care including emergency, surgical and cancer care. Its physicians and researchers are also engaged in a wide spectrum of translational-, clinical-, and population-focused research, with more than 2,900 active trials and a research portfolio amounting to $177 million. In 2024, most (need updated %) of University Hospitals Cleveland Medical Center's discharges were residents of Cuyahoga County.

Evaluation of Impact

University Hospitals Cleveland Medical Center Community Health Improvement Efforts

The following evaluation of impact pertains to the actions taken since the last Cuyahoga County CHNA in 2022. The assessment was done jointly between University Hospitals, the Cuyahoga County Board of Health, Cleveland Department of Public Health and other community partners and aligns with the State Health Assessment (SHA) and State Health Improvement Plan (SHIP). The 2022 CHNA was adopted by University Hospitals in September of 2022, and the 2023-2025 Implementation Strategy was adopted in March of 2023. This evaluation report covers the period January 2023– December 2024. Outcomes from the 2023-2025 period will be further analyzed in early 2026, in order to include 2025 progress in total, and to further inform prospective 2026 implementation strategies.

Upon review of the 2022 Community Health Needs Assessments, hospital staff for University Hospitals Cleveland Medical Center isolated two top priority community health needs:

1. Accessible and Affordable Health Care

2. Community Conditions

Within these areas, in consideration of the hospital's expertise and its being a community-based hospital, the following objectives were established:

- Reduce the incidence of cardiovascular disease among Cuyahoga county residents.
- Increase the survival rate of victims of gun violence at schools.
- Increase the survival rate of individuals experiencing cardiac arrests.
- Decrease late-stage diagnosis outcomes in breast and colorectal cancer with evidence-based screenings targeting high risk-sub populations.
- Reducing barriers to screening

- Increase collaboration with federally qualified health centers and other partners serving under-resourced communities to increase access to specialty care.

Address transportation and navigation barriers by providing services in the community via a mobile health unit.

- Improve overall health outcomes of patients by integrating resources to address social determinants of health.
- Reduce gun-related community violence, retaliation and recidivism.
- Increase the number of minority students to engage in various healthcare fields to create pathways for a more diverse and inclusive healthcare workforce.
- Build a pipeline of future healthcare professionals from Cleveland to increase access to care through culturally competent providers who reflect the communities they serve.

Impact

In 2023-2024, University Hospitals Cleveland Medical Center provided a variety of offerings across its enterprise including:

Harrington Heart and Vascular Institute

- Cardiovascular screenings: 11,168 participants; 5,432 screenings
- Education on heart health, CPR, AED, etc.: 18,966 participants
- CPR/AED training (Cardiac Free Zone initiative): 1,800 participants
- Stop the Bleed training (students): 1,603 participants

Community Safety

- Youth violence prevention programs: 5 events
- Vaping workshops: 12 workshops
- Stop the Bleed training (students): 1,603 participants (also listed under Harrington)

Seidman Cancer Center

- Cancer education and screenings: 6,295 participants; 45 screened
- Events targeting high-risk populations: 32 events
- Social determinants of health screenings: 9,486 individuals screened
- Food for Life Market (food distributed): 7,793 visits

Otis Moss Jr. Health Center

- Food for Life Market (food distributed): 2,809 visits
- Same-day/walk-in clinic patients: 554 patients
- Social determinants of health screenings: 941 individuals
- MedWorks pop-up clinic: 70 patients served

Adult Trauma Violence Interrupter Program

- Eligible participants engaged: 116 individuals
- Referrals to community services: 28 referrals
- Partnership with Cleveland Peacemakers Alliance: Ongoing, but limited due to staffing

Health Scholars Program

- Total students engaged: 224 students
- Workshops and events: 4 workshops (including 3 college tours and 1 movie night)
- Youth Summit: 300 attendees
- Goal: Equip 45 students annually for healthcare careers

Hospital Staff Interviews

In order to provide a qualitative context regarding University Hospitals Cleveland Medical Center successes and opportunities for improvement related to the implementation strategies, a discussion guide comprised of four anchor questions was utilized to frame an interview with University Hospitals Cleveland Medical Center leadership and caregivers from July 7-10, 2025.

9. What were the most significant successes and strategies in program implementation and community engagement?
10. What strategies experienced barriers to implementation, or were unable to be implemented?
11. How have community partnerships strengthened program implementation and community engagement?
12. Are there any opportunities that could potentially be leveraged in the future to improve the community's health?

As a result of this conversation, the following qualitative themes emerged pertaining to University Hospitals Cleveland Medical Center's community health implementation strategy from 2023-2025: 1. Community-Centered Engagement & Partnerships 2. Barriers to Implementation & Resource Constraints 3. Impact Through Health Education & Measurable Outcomes. The following quotes illustrate these themes:

Significant Success

"One of our most significant strategies is meeting people where they are—engaging with them directly in their communities, including at church events."

"We're focused on ensuring the program continues to grow—not just in the size of the cohorts we welcome each year, but also in the quality of the experiences we provide. It's important to elevate those experiences and gain more champions within the system so we can offer greater exposure and shadowing opportunities to the young people who join the program."

"One of our biggest successes has been the in-person advocacy carried out by hospital staff. She has taken the lead in engaging with patients, families, and the broader community. She also serves as the primary point of contact between the hospital and the Cleveland Peacemakers."

"One of our successes was that we partnered with the Northeast Ohio Quality Improvement (NEO) QI Hub on the Achieving Health Equity and Diabetes (AHEAD) initiative. The objective was to reduce the number of diabetic patients with hemoglobin A1c levels greater than 9%. We did this by implementing diabetes education, focusing on medication adherence, and self-monitoring of blood glucose. We increased access to Continuous Glucose Monitors (CGM). We facilitated the ordering and receiving of CGM's and ensured patients received proper training on their use. We increased the use of GLP-1 medications. Patients were engaged in shared decision-making to promote adherence. Through these targeted interventions, we achieved a 6% reduction in the number of participating patients with an A1c greater than 9%."

Barries to Implementation

"A major barrier to implementation has been a lack of staffing. However, in 2024, we hired an outreach nurse, which has played a pivotal role in effectively reaching the community."

"Beyond philanthropic support, we're looking for funders who are genuinely interested in sustaining this program. It's not a barrier, but the next step for me is figuring out how we can transition participants into employment within the system—and how to do that as smoothly as we do with other pipeline programs."

"Cancer care is incredibly complex, and financial barriers are a significant challenge. When we provide services to someone who is uninsured, there's no guarantee those services will be covered. That means we often have to seek alternative solutions to ensure patients receive the care they need—and that can be very difficult."

Community Partnerships

"Strengthening relationships has been incredibly valuable for us. Going out into the community, seeing what's available, and understanding what residents feel is necessary has been a tremendous asset."

"We partnered with the Cleveland Hearing and Speech Center, a nonprofit healthcare provider in Northeast Ohio that serves individuals with speech and hearing challenges. These issues can begin early in life—sometimes genetically or in utero—but also often occur after a stroke. This was especially relevant for our students, who are studying chronic diseases like hypertension, diabetes, stroke, and mental health this year. They're not only gaining exposure to healthcare careers and participating in college prep and community service, but they're also hosting a block party to educate the community. Some caregivers will even be conducting health screenings at the event."

"Community partners are essential to the success of our violence prevention programs. We continue to rely on organizations like the Cleveland Peacemakers and the Boys & Girls Club for referrals and external interventions."

"Our internal partnerships have played a vital role in implementing our programs. Collaborations with Dr. Randy Vince and the UH Cutler Center for Men have been especially impactful in increasing our visibility and community reach."

Future Opportunities

"This program allows us to give back to the community in meaningful ways—by connecting people to care and resources. What's even more powerful is that participants take what they learn home to their families, sparking important conversations and continuing the education. The goal is to create a ripple effect that benefits both the broader community and individual households."

"Another opportunity we could explore is expanding the program beyond violence-related trauma to include other forms of trauma, such as car accidents. This would allow us to provide broader support and partner with additional organizations."

"The chronic illnesses we frequently see in the clinic include diabetes, kidney disease, and hypertension. If we can work on lowering those and involve the community more, I believe we could make a real impact. I don't have all the answers on how to do that, but as a nurse, it's incredibly rewarding to see those numbers improve and our patients become healthier. We also have the Food for Life program, which is a great resource. She's available on-site to talk to patients about nutrition, diet, and exercise. I would love to see more outcomes data—specifically around A1C levels, blood pressure readings, and kidney health preservation."

Evaluation of Impact

University Hospitals Parma Medical Center

UH Parma Medical Center is a 287-bed community-based hospital located in Parma, OH that provides acute and subacute care to residents of Parma, Brooklyn, Seven Hills, North Royalton, and neighboring communities. With more than 911 physicians across 30 specialties, UH Parma Medical Center retains experts specializing in stroke, cardiac care, cancer, orthopedics, pain management, urology, acute rehabilitation, and bariatric care, and has received national accolades for both orthopedic and cardiovascular outcomes.

UH Parma Medical Center also provides radiology, diagnostic imaging, physical therapy, home healthcare, hospice, and screening and educational services, respectively. In 2021, most (87%) of University Hospitals Parma Medical Center's discharges were residents of Cuyahoga County.

Evaluation of Impact

University Hospitals Parma Medical Center Community Health Improvement Efforts

The following evaluation of impact pertains to the actions taken since the last Cuyahoga County CHNA in 2022. The assessment was done jointly between University Hospitals, Cuyahoga County Board of Health, Cleveland Department of Public Health and other community partners and aligns with the State Health Assessment (SHA) and State Health Improvement Plan (SHIP). The 2022 CHNA was adopted by University Hospitals in September of 2022, and the 2023-2025 Implementation Strategy was adopted in March of 2023. This evaluation report covers the period January 2023– December 2024. Outcomes from the 2023-2025 period will be further analyzed in early 2026, in order to include 2025 progress in total, and to further inform prospective 2026 implementation strategies.

Upon review of the 2022 Community Health Needs Assessments, hospital staff for University Hospitals Parma Medical Center isolated two

top priority community health needs:

1. Accessible and Affordable Healthcare
2. Community Conditions (Access to Healthy Food & Community Safety)

Within these areas, in consideration of the hospital’s expertise and its being a community-based hospital, the following objectives were established:

- Improve the wellbeing of adults in Cuyahoga County via chronic disease prevention and management; reduce incidence of diabetes and coronary heart disease and mortality.
- Reduce food insecurity for under-resourced older adults and children in the Parma, Parma Hts. and Seven Hills areas.
- Educate our communities on varies safety issues that impact their wellbeing.

Impact

Over the past two years, UH Parma Medical Center has made substantial progress in addressing community health needs through a wide range of initiatives focused on chronic disease prevention, food insecurity, community safety, and access to care. A total of 2,995 individuals were screened in 2023 and 4,044 in 2024 through 147 community-based events, including those held at the UH Parma Health Education Center, senior centers, and local libraries. These screenings were conducted across multiple zip codes and consistently reported no positive screening results, indicating strong preventive outreach.

In partnership with Sodexo and local senior centers, the hospital delivered 1,323 meals in 2023 and 1,696 in 2024 to older adults in Parma, Seven Hills, and Parma Heights through the Meals on Wheels program. Additionally, 533 meals were provided to children through the USDA Summer Lunch Program in 2023 and 437 in 2024. To further address food insecurity, Parma Medical Center distributed food pantry awareness materials at 76 events in 2023 and 112 in 2024, ensuring that residents were informed about local food resources.

Community safety was another key focus, with 42 safety-related events held in 2023 and 156 in 2024, reaching a combined total of 4,704 attendees. These events included fall prevention presentations, stroke and chest pain education, and balance screenings, particularly targeting older adults. Although car seat safety checks were discontinued, the hospital maintained its commitment to safety education through outreach at health fairs and senior centers.

Chronic disease prevention and management were addressed through a robust set of programs. In 2023, 438 individuals participated in nutrition and lifestyle education programs, and this number rose to 563 in 2024. These included cardiac and pulmonary rehab sessions, Core4 weight management programs, and support groups for stroke, arthritis, and Parkinson's disease. Medical Nutrition Therapy was also provided, with hundreds of initial and follow-up appointments conducted across both years. Educational materials were consistently distributed to inpatients with pre-diabetic A1C levels and to community members at screening events, along with financial assistance information for those with limited insurance coverage.

Overall, UH Parma Medical Center's efforts reflect a comprehensive, community-centered approach to improving health outcomes. Through consistent programming, strategic partnerships, and targeted outreach, the hospital has effectively addressed key social determinants of health and advanced its mission to support the well-being of residents in Parma and surrounding communities.

Hospital Leadership Interviews

In order to provide a qualitative context regarding University Hospitals Parma Medical Centers successes and opportunities for improvement related to the implementation strategies, a discussion guide comprised of four anchor questions was utilized to frame an interview with University Hospitals Parma Medical Centers leadership and caregivers on June 9, 2025.

1. What were the most significant successes and strategies in program implementation and community engagement?
2. What strategies experienced barriers to implementation, or were unable to be implemented?
3. How have community partnerships strengthened program implementation and community engagement?
4. Are there any opportunities that could potentially be leveraged in the future to improve the community's health?

As a result of this conversation, the following qualitative themes emerged pertaining to University Hospitals Parma Medical Center's community health implementation strategy from 2023-2025: 1. Accessible and Affordable Healthcare, 2. Community Conditions (Access to Healthy Food & Community Safety) The following quotes illustrate these themes:

Accessible and Affordable Healthcare

UH Parma Medical Center has made significant strides in enhancing access to health care as part of its 2023–2025 Community Health Needs Assessment. With a focus on chronic disease prevention and management, the center has implemented a robust schedule of community-based events aimed at early detection and health education. These events, held at the Health Education Center, senior centers, and various community venues, have provided thousands of residents with free screenings and educational materials. The initiative not only targets the early signs of chronic conditions like diabetes and heart disease but also ensures that participants receive information about financial assistance and healthy lifestyle choices. As part of this outreach, UH Parma emphasizes the importance of community connection, stating, "We provide screenings in the community as a touch point to the health system. The strong partners that are aligned with UH make it possible that we participate in over 300 events per

year.” This collaborative approach has allowed the center to reach a broad demographic, reduce barriers to care, and promote long-term wellness across the region.

Community Conditions - Access to Healthy Food

At UH Parma Medical Center, addressing community conditions has been a key part of its strategy to improve overall health outcomes. The hospital has focused on social determinants of health such as food access, education, and outreach by embedding health services into trusted community spaces. Through partnerships with local community organizations, Parma has expanded into access to healthy foods and provided on-site health education. These efforts not only support nutrition but also serve as a gateway to chronic disease prevention. As one team member noted, “We provide education at nearby events like health fairs and senior centers. We have increased access to healthy foods in the last three years. This also provides an opportunity to provide diabetes education.” By meeting residents where they are and integrating health education into everyday community settings, UH Parma is helping to reduce barriers and promote long-term wellness.

Community Conditions - Community Safety

To enhance safety awareness among older adults, particularly around fall prevention and when to call 911, UH is partnering with the UH EMS Institute and the Cuyahoga County Parma-Powers Library. The initiative includes participating in and hosting events, presentations, and screenings at senior centers, the City of Parma Safety Day, and the library. Educational materials are distributed at these events to inform the public about senior safety and to raise awareness about child car seat safety checks.

Evaluation of Impact

University Hospitals Rainbow Babies & Children's Hospital

University Hospitals Rainbow Babies & Children's is a 244-bed full-service children's hospital and academic medical center located in Cleveland, OH. With access to more than 1,300 pediatric specialists, advanced treatments, and pediatric care innovations, and providing specialized care to infants, children, teens, and young adults less than 21 years of age, UH Rainbow Babies & Children's provides a complete range of care for upwards of 750,000 patient encounters each year and is among the largest pediatric care providers in the state of Ohio. In 2021, most (54%) of UH Rainbow Babies & Children's discharges were residents of Cuyahoga County.

Evaluation of Impact

University Hospitals Rainbow Babies & Children's Hospital Community Health Improvement Efforts

The following evaluation of impact pertains to the actions taken since the last Cuyahoga County CHNA in 2022. The assessment was done jointly between University Hospitals Cuyahoga County Board of Health, Cleveland Department of Public Health and other community partners and aligns with the State Health Assessment (SHA) and State Health Improvement Plan (SHIP). The 2022 CHNA was adopted by University Hospitals in September of 2022, and the 2023-2025 Implementation Strategy was adopted in March of 2023. This evaluation report covers the period January 2023– December 2024. Outcomes from the 2023-2025 period will be further analyzed in early 2026, in order to include 2025 progress in total, and to further inform prospective 2026 implementation strategies.

Upon review of the 2022 Community Health Needs Assessments, hospital leadership for University Hospitals Rainbow Babies & Children's Hospital isolated two top priority community health needs:

1. Community Conditions

2. Accessible and Affordable Healthcare/Behavioral Health

Within these areas, in consideration of the hospital's expertise and its being a community-based hospital, the following objectives were established:

- Reduce the percentage of patients who report they cannot access enough healthy food for themselves, or their children & provide additional social support as needed.
- To improve health outcomes for at-risk pregnant women and infants by decreasing preterm birth & low birth weight, reducing mental and social stress, and increasing healthy behaviors (breastfeeding, safe sleep & smoking cessation).

- Reduce re-injury rate for children ages 6-15 who live in Cuyahoga County and are treated at UH Rainbow Babies & Children's Hospital for non-accidental injuries related to peer or community violence.

Impact

UH Rainbow Babies & Children's Hospital has implemented a robust and multifaceted approach to improving community health outcomes, particularly for at-risk children and pregnant women. A major focus has been on addressing food insecurity and nutritional education. Through the Healthy Harvest Program, the hospital distributed fresh produce to over 3,300 families in 2023 and 3,230 families in 2024. Additionally, monthly cooking classes and the CORE 4 nutrition program—an 8-week series for children and caregivers—were held consistently, totaling 12 sessions annually. Emergency food bags were provided to 80 families in 2023 and 74 in 2024, while over 6,600 patients were screened for food insecurity across both years, with hundreds referred to community resources like the Greater Cleveland Food Bank.

In maternal and infant health, the Centering Pregnancy program enrolled 400 women over two years, aiming to reduce preterm births, low birth weight, and increase breastfeeding rates. The program achieved a 14% preterm birth rate and a 12.5% low birth weight rate, while 65% of mothers were breastfeeding at discharge. The hospital also supported diabetic pregnant women with produce bags and provided baby food education to new parents.

Behavioral health and trauma-informed care were also key priorities. Since its inception, the Antifragility Initiative served over 670 individuals affected by community violence, offering bedside support, referrals to social services, and PTSD screening for pediatric trauma patients. The hospital made 575 referrals to community services and began implementing standardized PTSD screening tools in collaboration with psychologists and trauma teams. Although the creation of a formal survivor network faced staffing and funding challenges, the hospital pivoted to offering trauma-informed programming for incarcerated youth and continued to build partnerships for pro-social activities.

Overall, UH Rainbow Babies & Children's Hospital demonstrated a strong commitment to addressing social determinants of health, reducing disparities, and improving outcomes through education, outreach, and strategic partnerships.

Hospital Leadership Interviews

In order to provide a qualitative context regarding University Hospitals Rainbow Babies & Children's Hospital successes and opportunities for improvement related to the implementation strategies, a discussion guide comprised of four anchor questions was

utilized to frame an interview with University Hospitals Rainbow Babies & Children's Hospital leadership and caregivers on July 8, 2025.

13. What were the most significant successes and strategies in program implementation and community engagement?
14. What strategies experienced barriers to implementation, or were unable to be implemented?
15. How have community partnerships strengthened program implementation and community engagement?
16. Are there any opportunities that could potentially be leveraged in the future to improve the community's health?

As a result of this conversation, the following qualitative themes emerged pertaining to University Hospitals Rainbow Babies & Children's Hospital community health implementation strategy from 2023-2025: 1. Community Conditions, 2. Accessible and Affordable Healthcare/Behavioral Health. The following quotes illustrate these themes:

Community Conditions

UH Rainbow Babies & Children's Hospital has prioritized addressing food insecurity and promoting healthy lifestyles through a variety of community-based programs. In 2023, they hosted 12 cooking classes in collaboration with Sodexo chefs and dietitians, and distributed 3,312 Healthy Harvest produce bags to families. Additionally, 80 emergency food bags were provided to patients identified as food insecure, and 4,574 individuals were screened for food insecurity, with over half screening positive for at least one social need.

A standout initiative is the CORE 4 program, an 8-week family nutrition and wellness course that includes shared meals, physical activity, and mental health support. As one team member shared, "We're proud of our produce bags that we do twice a month for our diabetes pregnancy support group. We're also proud of our Centering Pregnancy education called Core 4, which is a family healthy nutrition program that establishes healthy eating for the entire family." The program is supported by a multidisciplinary team including physicians, dietitians, and mental health professionals.

The hospital also maintains a strong partnership with the Greater Cleveland Food Bank, where families can access a range of services through a centralized portal. "At the Food Bank, families can apply for SNAP and Medicaid in one place. It's a one-stop shop that makes it easier for them to get the help they need," a staff member explained.

Additionally, the hospital's dietitian now plays a central role in all food-related programs. "Our dietitian now plans the meals and snacks for any of our efforts that include food. That wasn't happening before 2024, and her involvement has made a big difference," a team member noted.

Accessible and Affordable Healthcare/Behavioral Health

Rainbow's efforts to improve maternal and child health outcomes are reflected in their Centering Pregnancy program, which enrolled 158 women in 2023. The program aims to reduce preterm births, low birth weight, and increase breastfeeding rates. However, participation remains a challenge. "Centering is the program we are struggling the most with. We're putting in a lot of effort, but we fundamentally need pregnant women to come to prenatal care—whether they choose group care or individual visits," a team member noted.

The hospital also provided monthly stroke support groups, trauma-informed care, and PTSD screenings for pediatric trauma patients. The Antifragility Initiative served 225 families and made 149 referrals to community services in 2023 and 2024. The Antifragility Initiative and UH Rainbow Babies & Children's relies on a vast community network of providers and resources to meet the varied needs of families impacted by peer and community violence. To this end, the Antifragility Initiative team participates in multiple local efforts to address violence against children and firearm violence through Cleveland Thrive; the Euclid Hope Taskforce, Cuyahoga County Child Fatality Review Board; and the Northeast Ohio Gun Safety Coalition. "We have a long-standing partnership with the Cleveland Peacemakers. They often come directly to the hospital after a child is a victim of violence. They help with grief counseling and even funeral expenses," a staff member shared. Looking ahead, Rainbow is working to expand the Antifragility Working Group to ensure sustainable funding and broader access to trauma-informed services. "We're looking at how more children who are traumatized or have PTSD can benefit from this program. It includes social determinants navigation and trauma-informed cognitive behavioral therapy for up to a year after hospitalization," one leader explained.

Evaluation of Impact

University Hospitals St. John Medical Center

University Hospitals St. John Medical Center is a 124-bed community-based hospital located in Westlake, OH that provides comprehensive medical and surgical care for children and adults residing in western Cuyahoga County and eastern Lorain County.

In conjunction with an onsite diagnostic imaging and laboratory services centers, UH St. John Medical Center retains a 24/7 emergency room, as well as urology, orthopedic, and neurology care services, and a family birthing center. In 2021, most (54%) of University Hospitals St. John Medical Center's discharges were residents of Cuyahoga County.

Evaluation of Impact

University Hospitals St. John Medical Center Community Health Improvement Efforts

The following evaluation of impact pertains to the actions taken since the last Cuyahoga County CHNA in 2022. The assessment was done jointly between University Hospitals e Cuyahoga County Board of Health, Cleveland Department of Public Health and other community partners and aligns with the State Health Assessment (SHA) and State Health Improvement Plan (SHIP). The 2022 CHNA was adopted by University Hospitals in September of 2022, and the 2023-2025 Implementation Strategy was adopted in March of 2023. This evaluation report covers the period January 2023– December 2024. Outcomes from the 2023-2025 period will be further analyzed in early 2026, in order to include 2025 progress in total, and to further inform prospective 2026 implementation strategies.

Upon review of the 2022 Community Health Needs Assessments, hospital leadership for University Hospitals St. John Medical Center isolated two top priority community health needs:

1. Behavioral Health (mental health & substance use and misuse)
2. Chronic Disease

Within these areas, in consideration of the hospital's expertise and its being a community-based hospital, the following objectives were established:

- Educate the community on dangers of substance use/misuse, strategies to improve mental health and resources offered in their community.
- Improve the wellbeing of adults in Cuyahoga County via chronic disease prevention and providing tools for disease self-management, particularly for diabetes and heart disease

Impact

UH St. John Medical Center has made significant strides in addressing community health needs through a comprehensive set of initiatives focused on behavioral health, chronic disease prevention, and community engagement. Over the course of 2023 and into 2024, the hospital reached a total of 2,313 individuals through behavioral health outreach events. These included partnerships with schools, local organizations like LCADA and the Far West Center, and events at high schools and senior centers. The hospital emphasized mental health education, substance misuse awareness, and community-based collaboration.

In terms of accessible and affordable healthcare, UH St. John conducted 6,117 health screenings across both years, targeting chronic diseases such as diabetes and coronary heart disease. These screenings were held at a wide range of venues including senior centers, community fairs, and corporate health events. Additionally, 1,754 individuals participated in nutrition and healthy lifestyle education programs, which included CPR training, stroke education, and wellness talks at schools and senior centers.

The hospital also launched a stroke prevention program, screening 294 individuals since its inception in August 2023. Strategic partnerships were formed with multiple new organizations such as Brightview, Riveon, and Lorain County Community College, enhancing the hospital's reach and impact.

Overall, UH St. John Medical Center's efforts reflect a strong commitment to improving community health through education, early detection, and collaborative outreach. Their work has not only increased health literacy but also built a more connected and health-conscious community.

Hospital Leadership Interviews

In order to provide a qualitative context regarding University Hospitals St. John Medical Centers successes and opportunities for improvement related to the implementation strategies, a discussion guide comprised of four anchor questions was utilized to frame an interview with University Hospitals St. John Medical Centers leadership and caregivers on June 23, 2025.

17. What were the most significant successes and strategies in program implementation and community engagement?
18. What strategies experienced barriers to implementation, or were unable to be implemented?
19. How have community partnerships strengthened program implementation and community engagement?
20. Are there any opportunities that could potentially be leveraged in the future to improve the community's health?

As a result of this conversation, the following qualitative themes emerged pertaining to University Hospitals St. John Medical Center's community health implementation strategy from 2023-2025: 1. Behavioral health 2. Chronic disease. The following quotes illustrate these themes:

Behavioral Health

Behavioral health has been a central pillar of UH St. John Medical Center's community outreach strategy, with a strong emphasis on education, prevention, and collaboration. Over the course of 2023 and 2024, the hospital reached more than 2,300 individuals through behavioral health-focused events. These initiatives were designed to increase awareness of mental health challenges, substance misuse, and available resources. A standout feature of their programming has been the engagement with local schools. As one team member shared, "We've also worked with high schools, where students are exposed to a wide range of topics including drug and opioid awareness, vaping, nutrition, and more. RBNC has participated by bringing in the blurred vision goggles, which students use while driving a small cart. It's a powerful experience that helps them understand the effects of impairment. The goggles are always a hit—they also try walking a straight line while wearing them, which really drives the message home." This hands-on, immersive approach has proven effective in delivering impactful lessons to young people. The hospital's outreach has even extended to elementary schools, where children are taught about handwashing and nutrition, and now includes partnerships with local libraries eager to host similar programming.

In addition to school-based efforts, UH St. John has cultivated partnerships with key behavioral health organizations such as LCADA and the Far West Center. These collaborations have enabled the hospital to broaden its reach and deepen its impact. A particularly promising development is the hospital's growing relationship with Riveon, a provider of mental health and addiction services in Lorain County. As one leader noted, "We're currently working across both Lorain and Cuyahoga Counties. I serve on the board for Riveon, which provides mental health and addiction services in Lorain County. What's exciting is that they're beginning to expand into Cuyahoga County, and I'm really looking forward to exploring how we can collaborate and bring those valuable services to more of our communities." This cross-county collaboration reflects UH St. John's commitment to addressing behavioral health holistically and equitably, ensuring that support reaches individuals across geographic and demographic boundaries.

Chronic Disease

Chronic disease prevention and management has been a cornerstone of UH St. John Medical Center's community health strategy, with a strong emphasis on early detection, education, and lifestyle support. In 2023 and 2024, the hospital reached over 6,100 individuals through free health screenings focused on conditions such as diabetes and

coronary heart disease. These screenings were held at a wide range of community venues, including senior centers, libraries, corporate health fairs, and public safety events. The hospital also provided nutrition and healthy lifestyle education to more than 1,700 participants, offering CPR training, stroke education, and wellness talks tailored to older adults and at-risk populations.

The success of these programs has not gone unnoticed. As one team member shared, “Word has spread through other organizations—people are reaching out saying, ‘We heard you did this for another group, would you be willing to come to us?’ I think the reputation we’ve built in the community is having a significant impact.” This growing demand reflects the trust UH St. John has cultivated through consistent, high-quality outreach. Another highlight was the hospital’s participation in community-wide events like Safety Day, which drew strong attendance and engagement. “It was great to get out into new areas of the community and build fresh connections. We had a strong showing at our Safety Day event, which was another big success. It’s always rewarding to see such positive engagement,” a staff member noted. These efforts underscore the hospital’s commitment to not only treating chronic conditions but also empowering individuals with the knowledge and tools to lead healthier lives.

University Hospitals

Community Health Needs Assessment

2025

Cuyahoga County