Cleveland Clinic Children's
Hospital for Rehabilitation

Community Health Needs Assessment

2025



Table of Contents

Cleveland Clinic Children's Hospital for Rehabilitation 2025 Community Health Needs Assessment 3

Introduction 3
Children's Hospital for Rehabilitation Community Definition 4
Summary 6
Prioritized Health Need #1: Access to Healthcare 7
Prioritized Health Need #2: Behavioral Health 9
Prioritized Health Need #3: Chronic Disease Prevention and Management 11
Prioritized Health Need #4: Maternal and Child Health 12
Prioritized Health Need #5: Health-Related Social Needs 14
Prioritized Health Needs in Context 15
Secondary Data Overview 16
Primary Data Overview 29
Prioritization Methodology 31
Collaborating Organizations 32
Community Partners and Resources 32
Comments Received on Previous CHNA 33
Request for Public Comment 34
Appendices Summary 34
Appendix A: CCCHR Community Definition 35
Appendix B: Secondary Data Sources and Analysis 36
Appendix C: Environmental Scan and Key Findings 176
Appendix D: Community Input Assessment Tools and Key Findings 177
Appendix E: Impact Evaluation 186
Appendix F: Acknowledgements 189

Cleveland Clinic Children's Hospital for Rehabilitation Implementation Strategy Report 191

Cleveland Clinic Children's Hospital for Rehabilitation 2025 Community Health Needs Assessment

Introduction

The Cleveland Clinic Children's Hospital for Rehabilitation (CCCHR) is a 25 bed[1] hospital located in Cleveland, Ohio that offers inpatient care, day hospital care and a comprehensive range of inpatient and outpatient services. The hospital is accredited by the Commission on Accreditation of Rehabilitation Facilities and is a CARF-accredited, freestanding pediatric rehabilitation hospital. It offers specialized pediatric and rehabilitative services, including behavioral health, neurology, nephrology, and occupational, physical, and speech therapy. The Cleveland Clinic Children's Center for Autism is also housed within CCCHR. The Center for Autism provides innovative, community-based interventions for children with autism while advancing professional training and research.

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

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

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

The Cleveland Clinic's legacy as a pioneering institution began in 1921 as a multispecialty group practice, and it continues to lead through medical firsts, global expansion, and a commitment to community health. Today, CCCHR exemplifies this

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

vision by delivering high-quality care, supporting health-focused research, and fostering community partnerships that help address both medical and social drivers of health.

CCCHR is a trusted part of the community and continues to grow and improve to meet the needs of its patients. To learn more, visit: my.clevelandclinic.org/pediatrics/locations/rehabilitation-hospital/about

CHNA Background

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

Cleveland Clinic Children's Hospital for Rehabilitation Community Definition

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

Figure 1: CCCHR Community Definition

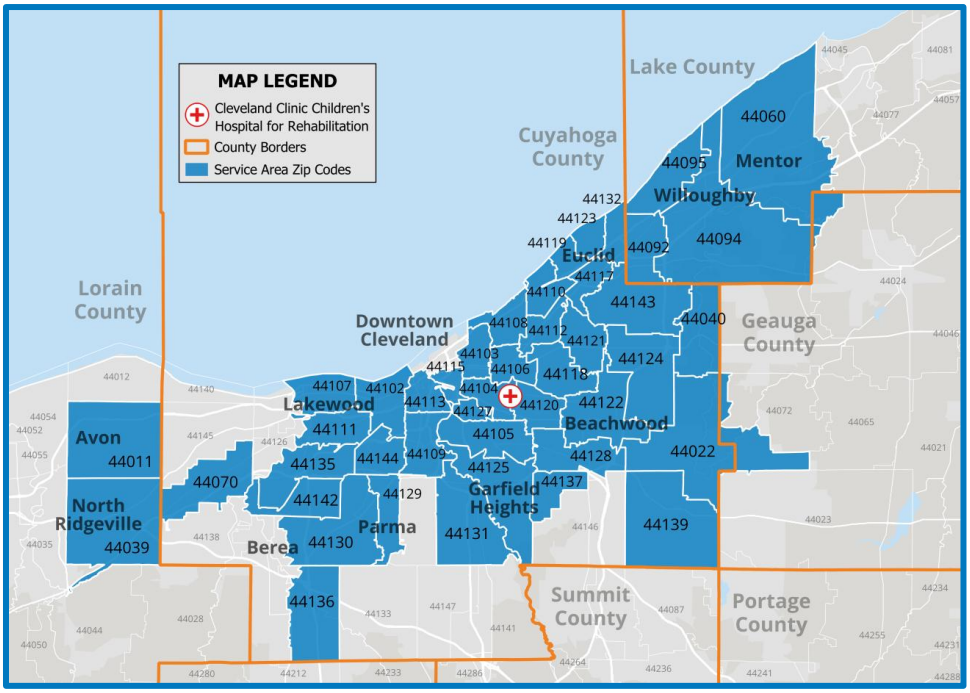


Table 1: CCCHR Community Definition

Zip Code	Postal Name	Zip Code	Postal Name	Zip Code	Postal Name
44011	Avon	44108	Cleveland	44125	Cleveland
44022	Chagrin Falls	44109	Cleveland	44127	Cleveland
44039	North Ridgeville	44110	Cleveland	44128	Cleveland
44040	Gates Mills	44111	Cleveland	44129	Cleveland
44060	Mentor	44112	Cleveland	44130	Cleveland
44070	North Olmsted	44113	Cleveland	44131	Independence
44092	Wickliffe	44115	Cleveland	44132	Euclid
44094	Willoughby	44117	Euclid	44135	Cleveland
44095	Eastlake	44118	Cleveland	44136	Strongsville
44102	Cleveland	44119	Cleveland	44137	Maple Heights
44103	Cleveland	44120	Cleveland	44139	Solon
44104	Cleveland	44121	Cleveland	44142	Brookpark
44105	Cleveland	44122	Beachwood	44143	Cleveland
44106	Cleveland	44123	Euclid	44144	Cleveland
44107	Lakewood	44124	Cleveland		

Secondary Data Methodology and Key Findings

Secondary Data Scoring

Secondary data used for this assessment were collected and analyzed from Conduent Healthy Communities Institute's (HCI) community indicator database. The database, maintained by researchers and analysts at HCI, includes 300 community indicators covering at least 28 topics in the areas of health, health-related social needs, and quality of life. The data are primarily derived from state and national public secondary data sources such as the U.S. Census American Community Survey (ACS Survey), Centers for Disease Control & Prevention (CDC), Centers for Medicare & Medicaid Services (CMS), County Health Rankings, Feeding America, and the National Cancer Institute. These indicators were analyzed at both the county level and within a defined 44-zip-code community area. Data were compared to national benchmarks, state averages, and historical trends to identify areas of concern. The analysis reinforced five key health priorities, Access to Healthcare, Behavioral Health, Chronic Disease Prevention and Management, Maternal and Child Health, and Health-Related Social Needs, highlighting differences in outcomes by group.

Other Community Assessment and Improvement Plans

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

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

Primary Data Methodology and Key Findings

To ensure community priorities and lived experience were centered in this assessment, conversations with community stakeholders were conducted across the CCCHR community. These conversations included individuals from 14 organizations who spoke directly to the needs within the CCCHR community. Participants represented sectors including public health, mental health, housing, food access, child and family services, and grassroots organizations. Feedback consistently reinforced the five identified health priorities and revealed community-specific challenges affecting health outcomes, such as long wait times for pediatric care, gaps in behavioral health support, housing-related health risks, and challenges accessing culturally responsive prenatal care. Financial hardship was described as a root cause affecting every other health domain. Stakeholders called for expanded prevention, investment in community infrastructure, and systems-level changes that address the underlying conditions shaping health across generations.

Summary

2025 Prioritized Health Needs

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

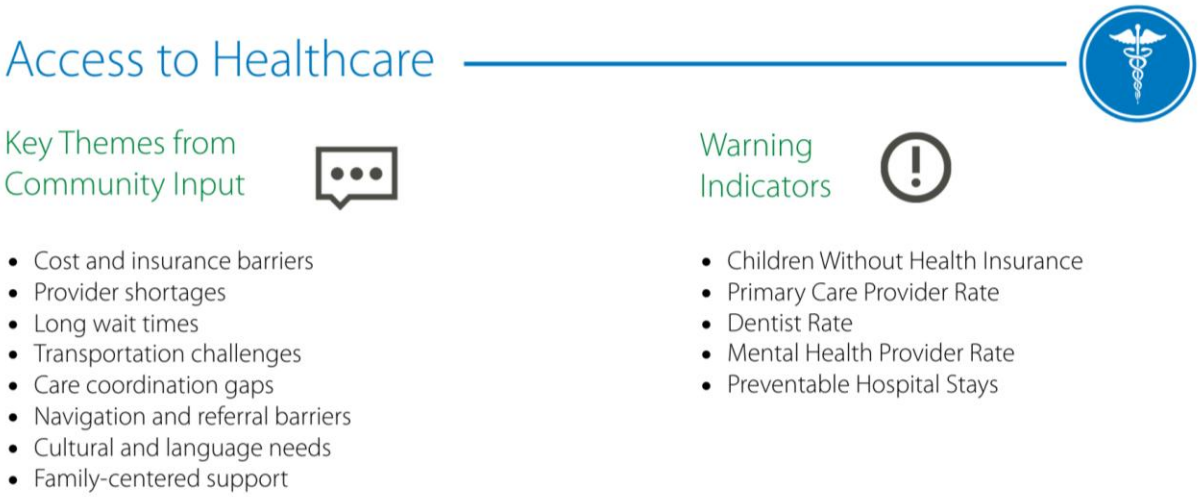


These priorities reflect persistent and deeply interconnected challenges, such as provider shortages, care affordability, mental health access, chronic disease burden, and the health impacts of poverty and neighborhood conditions. Community input, coupled with data showing that Cuyahoga, Lake, and Lorain counties continues to exceed state and national benchmarks in these areas, underscores the urgency of sustained, cross-sector

efforts to address differences in health outcomes and improve health outcomes for all populations in the community served by CCCHR.

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

Prioritized Health Need #1: Access to Healthcare



Access to Healthcare emerged as a central theme across stakeholder interviews for the Cleveland Clinic Children's Hospital for Rehabilitation community. Participants emphasized that while the region benefits from strong healthcare infrastructure and highly specialized services, many residents still experience significant barriers to obtaining timely and affordable care. Cost and insurance limitations were among the most commonly cited challenges, particularly for families of children with complex medical or developmental needs. Stakeholders described how high deductibles, limited coverage for rehabilitative or behavioral health services, and delays in insurance approvals can create financial strain and treatment interruptions. They also noted that transportation barriers, long wait times, and workforce shortages contribute to uneven access, especially for low-income families and those living farther from major healthcare centers.

Stakeholders highlighted the importance of care coordination and navigation support, explaining that families often struggle to manage multiple appointments, referrals, and services across different systems of care. Parents of children with chronic conditions or disabilities face additional challenges in identifying providers who offer both specialized expertise and family-centered support. Participants emphasized that language, cultural, and digital barriers further complicate access, leading to missed appointments and inconsistent follow-up. Several stakeholders expressed that navigating healthcare and social services can be overwhelming without case management or community health worker assistance.

Overall, stakeholder feedback reflected a strong consensus that improving access to healthcare requires not only expanding availability and affordability but also simplifying the patient and family experience. Stakeholders recommended strengthening integrated care models that connect medical, rehabilitative, and behavioral health services, while also investing in outreach, telehealth, and family navigation supports. Participants underscored that ensuring accessible, culturally responsive, and coordinated care is essential to improving health outcomes within the CCCHR community.

Secondary data indicate that the vast majority of children in both Cuyahoga and Lake counties have health insurance (96.4% and 97.8%, respectively), although this rate is somewhat lower in Cleveland, specifically (95.8%). Data from Cuyahoga County indicate 73.4% of high school students receiving an annual physical exam, although these rates are lower for the county's Black/African American and Hispanic/Latino high school students (62.3% and 66.3%, respectively). For the CCCHR community's Lake County population, one potential barrier to regular, preventive care is the low availability of primary care providers across the county (41.4 per 100,000).

Geospatial data from Conduent HCI's Community Health Index (CHI) can help to estimate health risk based on health-related social needs. At the zip code level, the highest index values and greatest healthcare needs are in the zip codes surrounding Downtown Cleveland, including 44115, 44104, 44127, and 44103. Additional details about the CHI, including charts, maps, and additional findings from primary and secondary data for this health need can be found in the appendices section of this report.

Prioritized Health Need #2: Behavioral Health



Behavioral Health was identified as a major and growing concern across stakeholder interviews for the CCCHR community. Participants emphasized that children and adolescents are experiencing rising rates of anxiety, depression, and behavioral challenges, often linked to social isolation, family stress, and trauma. Stakeholders noted that the demand for pediatric behavioral health services has increased sharply, outpacing available resources and creating long wait times for counseling and psychiatric care. Many families face difficulty finding specialized providers who are trained to support children with developmental or neurological differences. Stakeholders also expressed concern about the shortage of inpatient and step-down behavioral health options for youth with complex medical and emotional needs, leading to longer hospital stays or repeated emergency department visits.

Access and affordability were described as significant barriers to behavioral health care. Participants highlighted that even when services exist, limited insurance coverage, transportation challenges, and workforce shortages make consistent engagement difficult. The stigma surrounding behavioral health was also cited as a persistent obstacle that discourages early intervention, particularly among families concerned about judgment or misunderstanding of behavioral diagnoses. Stakeholders emphasized that families often struggle to balance medical, educational, and behavioral health needs without coordinated support systems, leading to care fragmentation and burnout.

Overall, stakeholders called for a more integrated and family-centered approach to behavioral health care within the CCCHR community. Expanding access to outpatient therapy, crisis response services, and school-based behavioral health programs was identified as a critical priority. Participants also emphasized the need for multidisciplinary coordination between pediatricians, therapists, educators, and social workers to ensure that behavioral health care is continuous and tailored to the needs of children and families managing complex conditions.

Secondary data findings demonstrate some improvements regarding behavioral and mental health challenges. Cuyahoga County has seen decreasing levels of substance use among high school students, with the latest data demonstrating lower levels of students

using alcohol (14.9%) and marijuana (15.4%), as well as decreasing levels of students who drive after drinking alcohol (3.2%).

Some mental health outcomes have also demonstrated improvement in Cuyahoga County. Rates of both depression and self-harm among students decreased for the first time in a decade, after years of increase. In contrast, the percent of students attempting suicide had been decreasing for years, but the most recent data did not show any improvement. All three of these health outcomes are more likely to impact high school girls, Black/African American and Hispanic/Latino students, and LGBTQ students. For example, more than a fifth of gay, lesbian, and bisexual students (21.9%) attempted suicide in the past year, compared to 7.6% of the overall student population.

Geographic analysis using Conduent HCI's Mental Health Index (MHI), which assesses mental health risk based on local health-related social needs indicators, demonstrates a high burden of behavioral health needs across the population served by CCCHR. The majority of zip codes in the community (34 out of 44) scored above 75 on the MHI scale, and nine had an MHI value above 99: the Cleveland zip codes 44104, 44103, 44108, 44112, 44105, 44110, 44128, and 44115, as well as the Euclid zip code 44117.

Prioritized Health Need #3: Chronic Disease Prevention and Management



Stakeholders described Chronic Disease Prevention and Management as an ongoing challenge for both children and adults within the Cleveland Clinic Children's Hospital for Rehabilitation community. Participants emphasized that many families face barriers to consistent follow-up care and preventive services due to transportation challenges, financial strain, and limited understanding of disease management. Conditions such as diabetes, asthma, obesity, and hypertension were frequently mentioned as concerns that require long-term coordination and education. Stakeholders noted that for pediatric populations, the management of chronic conditions is often complicated by social and behavioral factors, including family stress and inconsistent access to nutritious food or safe spaces for physical activity.

Participants also discussed how gaps in care coordination and communication between medical, school, and community systems create barriers to managing chronic conditions effectively. Families of children with complex or co-occurring conditions face additional challenges navigating multiple specialists and treatment plans. Stakeholders observed that while hospital-based specialty care is strong, access to preventive education, nutrition counseling, and community wellness resources remains uneven across the community. They emphasized that early intervention, parent education, and family-centered case management are essential to improving outcomes and reducing emergency visits or hospital readmissions.

Overall, stakeholder feedback highlighted the need for greater collaboration among healthcare providers, schools, and community organizations to support chronic disease management from a whole-family perspective. Participants called for expanded access to nutrition and wellness programs, consistent care coordination, and culturally responsive education tailored to family needs. Strengthening community-based prevention efforts, particularly those focused on healthy eating, physical activity, and early disease detection, was viewed as critical to improving long-term health and quality of life for CCCHR patients and families.

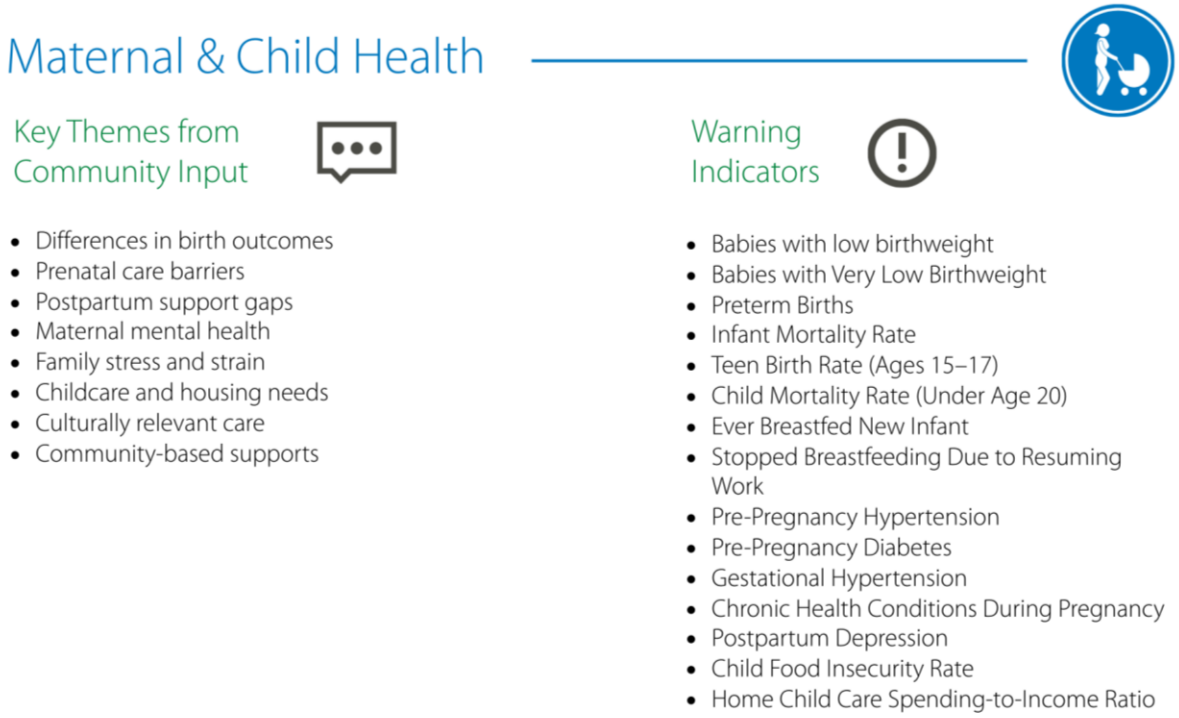
Local secondary data indicate that asthma affects about a tenth of young children in Cuyahoga County (9.9%), which is a decrease from the previous measurement cycle.

Likewise, Youth Risk Behavior Survey data show decreases across the county in high school students' use of vaping products (7.0%) and cigarettes (1.3%).

Challenges persist with regard to food access and nutrition. Residents of both Cuyahoga and Lake counties are broadly less likely to cook at home than most other U.S. counties. In Cuyahoga County specifically, there have also been increases in the percent of high school students reporting that they didn't eat any fruit or didn't eat any vegetables in the past week, or that they skipped breakfast. In fact, the child food insecurity rate in Cuyahoga County (26.0%) is one of the highest across the state and nation.

Conduent HCI's Food Insecurity Index (FII) can help pinpoint where food access concerns are greatest across the broader CCCHR population. At the zip code level, the highest levels of need are in the Cleveland zip codes 44104, 44115, and 44110, with FII values of 100, 99.9, and 99.0, respectively.

Prioritized Health Need #4: Maternal and Child Health



Stakeholders identified Maternal and Child Health as an important but unevenly addressed need within the Cleveland Clinic Children's Hospital for Rehabilitation community. Participants highlighted concerns about differences in birth outcomes, maternal health complications, and access to early childhood supports. Families facing financial hardship, housing instability, or limited transportation were described as being at highest risk for poor outcomes, often struggling to maintain consistent prenatal and pediatric care. Stakeholders also cited gaps in postpartum support, particularly related to maternal mental health, breastfeeding education, and family readiness to navigate the healthcare system after delivery.

Participants emphasized that maternal and child health is strongly influenced by broader social and systems-level factors. Many families experience stress linked to poverty, childcare barriers, and lack of access to affordable healthy food, which can affect both pregnancy outcomes and early childhood development. Stakeholders discussed the need for culturally relevant maternal care and the importance of trusted community-based programs such as home visiting and parenting support. Several participants noted that families of children with developmental or medical needs often face additional emotional and financial strain, highlighting the importance of care coordination and peer support to sustain family well-being.

Overall, stakeholder feedback underscored that improving maternal and child health in the CCCHR community requires a comprehensive, family-centered approach that extends beyond clinical care. Expanding access to prenatal and postpartum services, integrating mental health screening, and addressing social needs such as housing and nutrition were identified as key priorities. Strengthening partnerships between hospitals, public health programs, and community organizations was viewed as critical to ensuring healthy pregnancies, healthy births, and stronger long-term outcomes for children and families.

Secondary data demonstrate challenges regarding birthing outcomes that are especially pronounced in Cuyahoga County. The county-wide infant mortality rate is higher than the state-wide rate, and more than 50% higher than the Healthy People 2030 target (7.7 vs. 5.0 per 1,000). Cuyahoga County residents also experience elevated risks of low birthweight and preterm births. The risk of preterm birth in particular is higher for the county's Black/African American population (14.8% vs. 12.0% overall).

Cuyahoga County also has a relatively high teen birth rate. Despite an overall decrease over time, the county's current teen birth rate (7.3 per 1,000 teen girls) remains higher than most other counties across Ohio. Teen births can impact health outcomes of both the infant as well as the adolescent giving birth.

Autism Spectrum Disorder

Stakeholders described Autism Spectrum Disorder (ASD) as a growing priority within the Cleveland Clinic Children's Hospital for Rehabilitation community, emphasizing the need for earlier diagnosis, greater access to therapy, and stronger coordination of care. While the Cleveland Clinic Children's Center for Autism was recognized as a valuable resource, families continue to face long wait times, limited insurance coverage, and shortages of trained providers for behavioral and developmental services. Participants highlighted gaps in continuity of care, particularly during transitions between early intervention, school, and adult systems, as well as the financial and emotional strain placed on caregivers. Stakeholders underscored the importance of family-centered case management, culturally responsive outreach, and collaboration among healthcare, education, and social service systems to expand support for all populations of children with autism and their families.

The prevalence of Autism Spectrum Disorder (ASD) is increasing in Cleveland Clinic Children's Hospital for Rehabilitation communities. Medicaid data indicate that ASD prevalence in Ohio has more than doubled among Medicaid recipients between 2012 and

2022, increasing from 1 in 122 children to 1 in 50 children.2 Children with ASD experience higher rates of co-occurring medical conditions than children without ASD, including higher rates of depression, anxiety, epilepsy, vision or hearing impairment, and gastrointestinal issues.[3]

Prioritized Health Need #5: Health-Related Social Needs



Stakeholders across the Cleveland Clinic Children's Hospital for Rehabilitation community emphasized that Health-Related Social Needs have a direct and significant impact on families' ability to maintain health and access needed care. Participants described how poverty, housing instability, food insecurity, and limited transportation contribute to poor health outcomes and create barriers to consistent medical follow-up. Many families of children with special health or developmental needs face competing priorities between paying for daily living expenses and affording healthcare or therapy services. Stakeholders noted that these challenges are often compounded by a lack of awareness of available community resources and the difficulty of navigating complex service systems.

Housing and transportation emerged as particularly pressing issues. Participants explained that families living in unstable or unsafe housing conditions often experience stress and disrupted care routines, while unreliable or inaccessible transportation makes

[2] Center for Disease Control and Prevention. Autism Spectrum Disorder: Autism Data Visualization Tool. https://www.cdc.gov/autism/data-research/autism-data-visualization-tool.html
[3] Bougeard, C., Picarel-Blanchot, F., Schmid, R., Campbell, R., & Buitelaar, J. (2021). Prevalence of autism spectrum disorder and co-morbidities in children and adolescents: A systematic literature review. *Frontiers in psychiatry, 12*, 744709. https://doi.org/10.3389/fpsyt.2021.744709

it difficult to attend appointments, particularly for ongoing rehabilitation and therapy services. Food insecurity and limited access to affordable, nutritious options were also identified as widespread concerns affecting both child and adult health. Stakeholders emphasized that while many organizations are working to address social needs, coordination across agencies remains limited, and families often need additional support connecting to and sustaining services.

Overall, stakeholder feedback highlighted that addressing Health-Related Social Needs requires a coordinated, family-centered approach that integrates medical and social care. Participants called for greater collaboration between hospitals, schools, and community-based organizations to identify and address basic needs early. Expanding access to case management, community health workers, and social needs screening within healthcare settings was viewed as essential to improving stability, reducing stress, and enhancing long-term health outcomes for families served by the CCCHR community.

Based on scoring of secondary data indicators, the topics of Economy and Education were both especially concerning in Cuyahoga County. The percent of children living in poverty (23.2%) is one of the highest across the state, and is higher for the county's Black/African and Hispanic/Latino children (38.6% and 30.3%, respectively). Many basic needs, including education, are financially burdensome across the county. The typical costs of housing (19.3% of household income for renters), home childcare (3.8%), day care and preschool (8.7%), and college tuition (14.7%) all surpass state and national averages.

Social connections and isolation are also areas of concern across this community. Both Cuyahoga and Lake counties have relatively high rates of youth not in school or working, and the Cuyahoga County rate of children in single-parent households is one of the highest across the state and nation. Lake County, specifically, also has an especially high rate of grandparents who are responsible for their grandchildren that continues to increase. Although grandparents may experience some psycho-social benefits as primary caregivers, they are also likely to experience limitations in fulfilling those responsibilities.

Prioritized Health Needs in Context

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

Secondary Data Overview

Demographics and Health-Related Social Needs

The demographics of a community significantly impact its health profile.[4] Different groups may have unique needs and require varied approaches to health improvement efforts. The following section explores the demographic profile of the community served by Cleveland Clinic Children's Hospital for Rehabilitation (CCCHR), including the economic, environmental, and social drivers of health. The social drivers of health are the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, and political systems.[5] In addition to these highlights, detailed findings from the secondary data analysis can be found in Appendix B.

Geography and Data Sources

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

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

Population Demographics of the CCCHR Community

According to the 2024 Claritas Pop-Facts® population estimates, the CCCHR community has an estimated population of 1,158,158 persons, with more than 80% residing in Cuyahoga County. The median age in the community is 41.7 years, which is older than that of Ohio (40.3 years). About a fifth of the population (19.9%) are under the age of 18.

Just over half the population are White (57.1%). Under a third are Black or African American (29.7%) and 7.3% are Hispanic or Latino of any race.

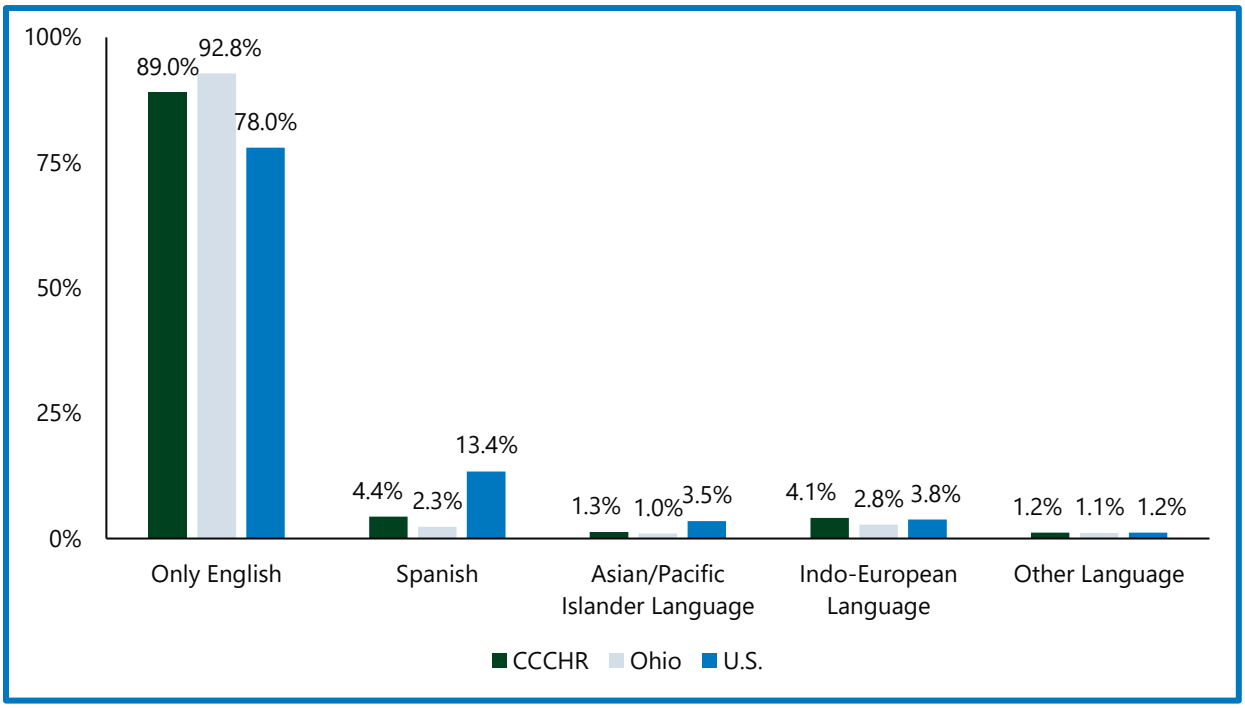
As seen in Figure 2, the majority of CCCHR's population aged five and above speaks primarily English at home (89.0%), and 5.4% speak Spanish at home. Understanding countries of origin and language spoken at home can help inform the cultural and linguistic context for the health and public health system. Primary language spoken in the home can also be a proxy for acculturation into the community.

---

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

[5] Centers for Medicare and Medicaid (CMS) (2025). Social Drivers of Health and Health-Related Social Needs. https://www.cms.gov/priorities/innovation/key-concepts/social-drivers-health-and-health-related-social-needs

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



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

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

Income and Poverty

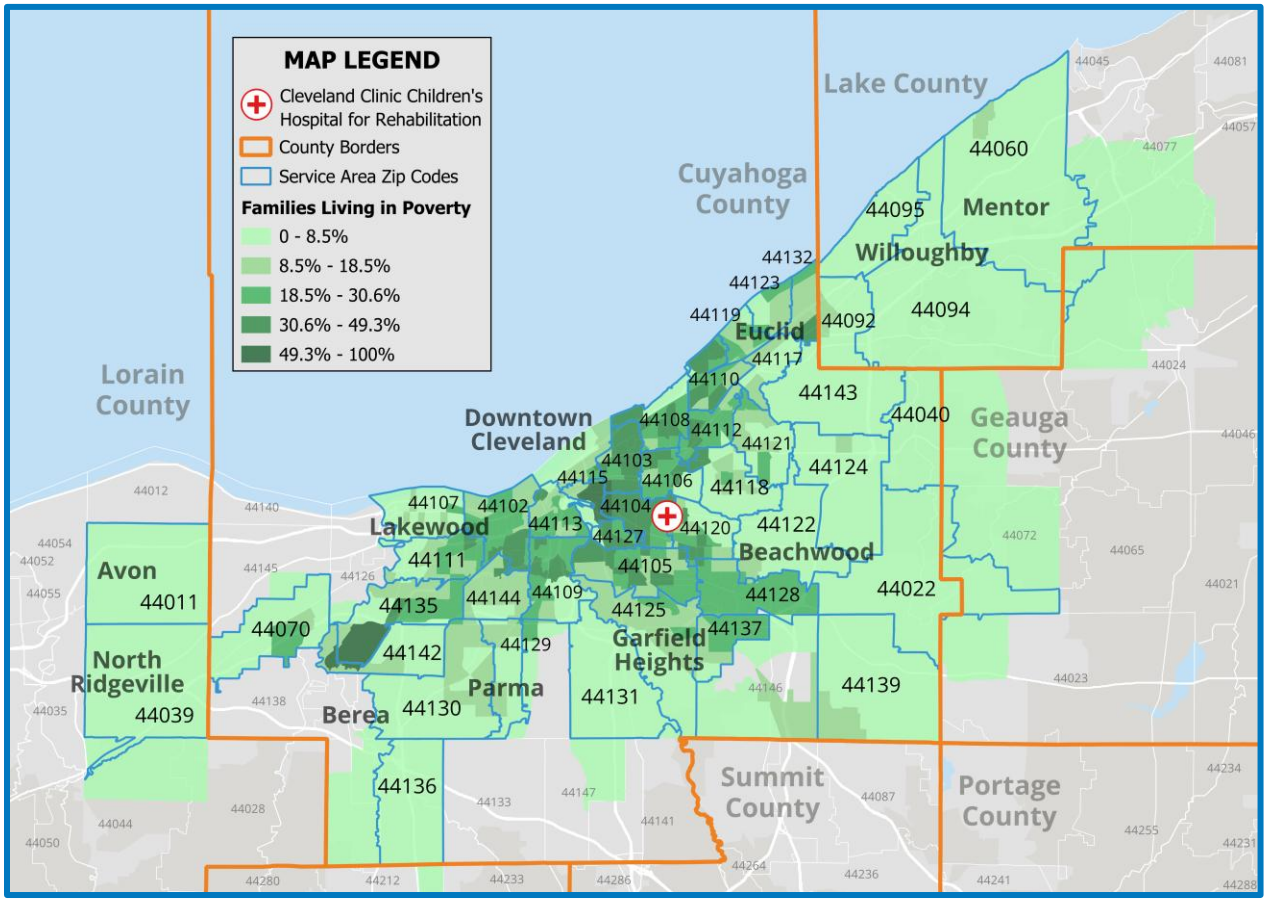
Income has been shown to be strongly associated with morbidity and mortality, influencing health through various clinical, behavioral, social, and environmental factors. Those with greater wealth are more likely to have higher life expectancy and reduced risk of a range of health conditions including heart disease, diabetes, obesity, and stroke. Poor health can also contribute to reduced income by limiting one's ability to work.[6]

The median household income for the CCCHR community is $63,614 which is comparable to that of Ohio overall ($68,488).

Federal poverty thresholds are set every year by the Census Bureau and vary by size of family and ages of family members. Across the CCCHR community, 12.4% of families live below the poverty level, and 9.3% of families live below poverty with children. Poverty levels differ geographically across the hospital community (Figure 3), and poverty is most common in the zip code 44115 (Cleveland, Industrial Valley), where 58.5% of families live in poverty and 49.6% of families live in poverty with children.

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

Figure 3: Families in Poverty by Census Tract, CCCHR Community

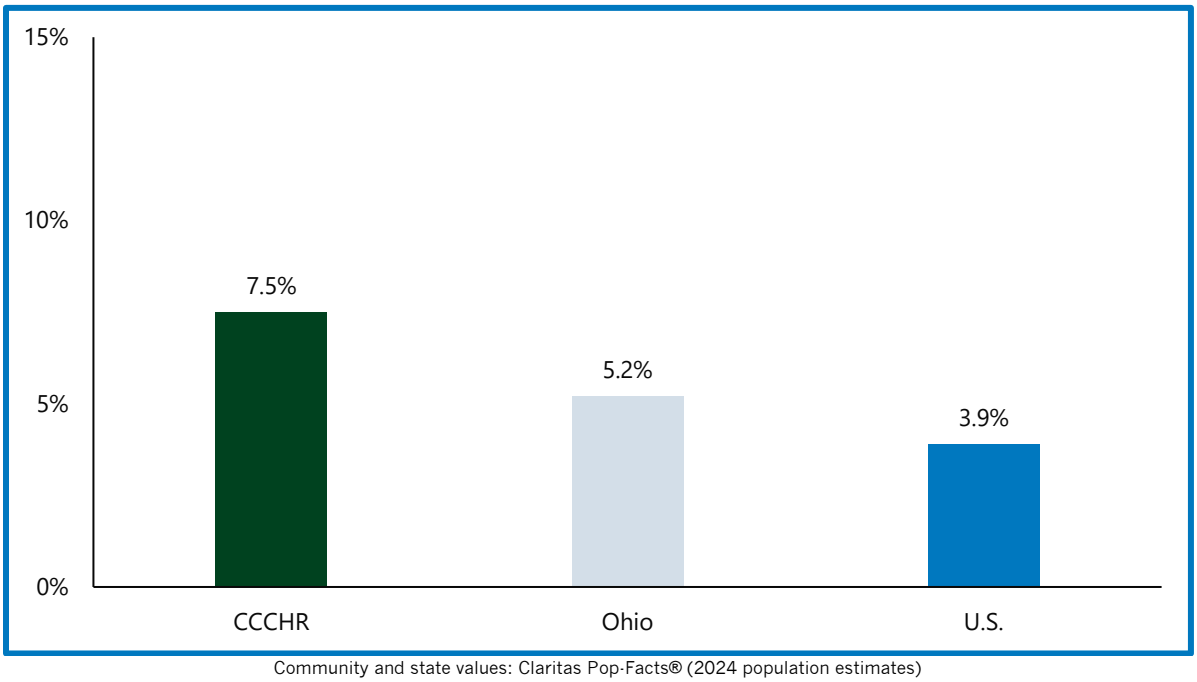


Claritas Pop-Facts® (2024 population estimates)

Education and Employment

The vast majority of the population within the CCCHR community have a high school degree or higher (90.6%) and about a third have a bachelor's degree or higher (32.9%). These rates are comparable to state-wide and national rates. As seen in Figure 4,the unemployment rate is 7.5%, which is higher than the Ohio unemployment rate (5.2%).

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



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

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

Education is an important indicator of health and wellbeing. Education can lead to improved health by increasing health knowledge, providing better job opportunities and higher income, and improving social and psychological factors linked to health.[7] Higher levels of education may also lead to better job opportunities which, in turn, impact health. An individual's type and level of employment impacts access to healthcare, work environment, health behaviors, and health outcomes.[8]

Housing and Built Environment

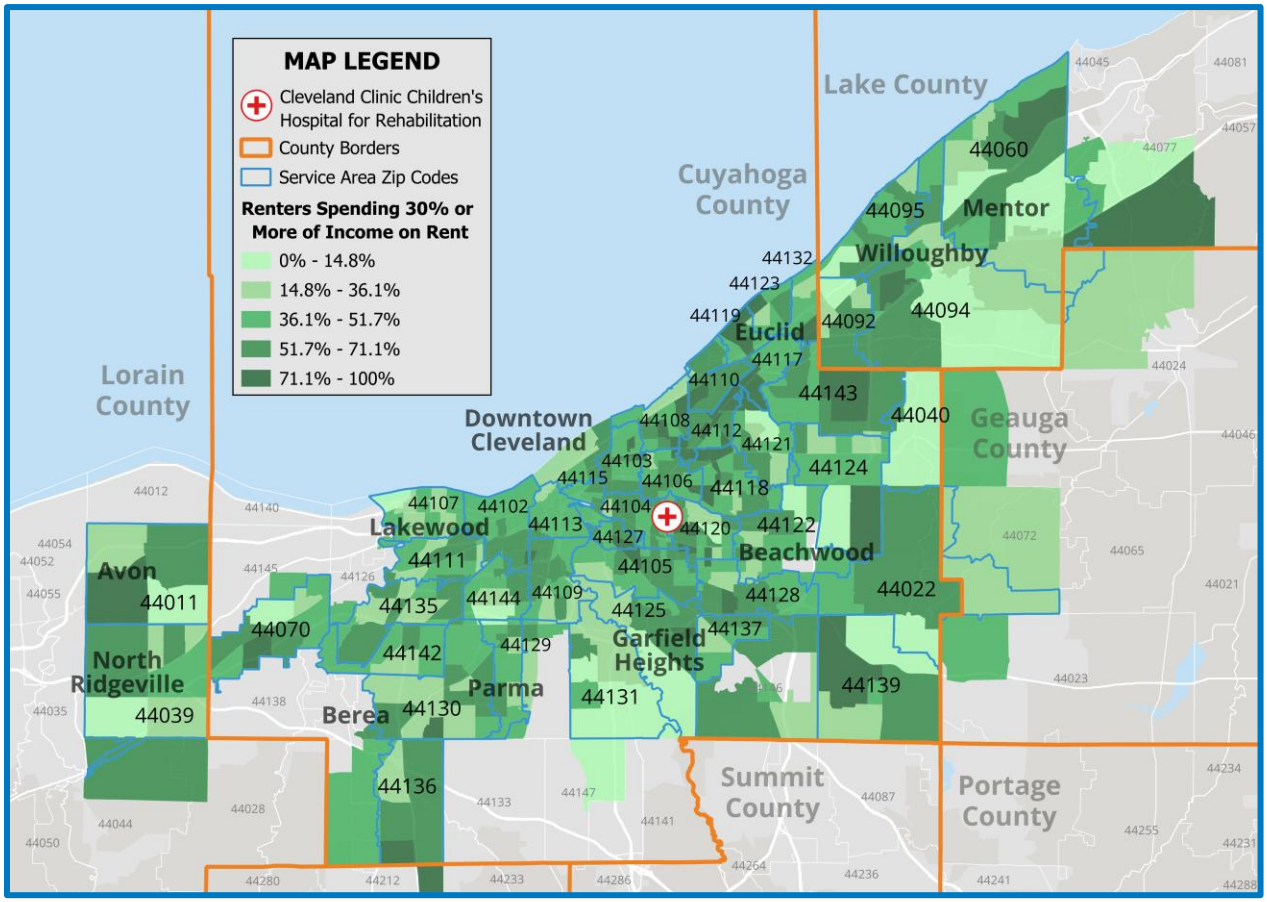
Safe, stable, and affordable housing provides a critical foundation for health and well-being. The analysis examined how many renters across the CCCHR community experienced a high rent burden, defined as spending 30% or more of their household income on housing. It also assessed the prevalence of severe housing problems, including overcrowding, high housing costs, lack of a kitchen, or lack of plumbing facilities.

At the county level, 47.5% of renters in Cuyahoga and 46.0% of renters in Lake had a high rent burden. Cuyahoga County also had a higher percentage of households with severe problems (15.9%), followed by Lake County (9.9%).

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

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

Figure 5: High Rent Burden by Census Tract, CCCHR Community



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

Home internet access is an essential home utility for accessing healthcare services, including making appointments with providers, getting test results, and accessing medical records. The majority of households in both Cuyahoga and Lake counties have an internet (87.5% and. 91.9%, respectively). The lowest levels of internet access in the CCCHR community are in the Cleveland zip codes 441104 and 44127, where 69.3% and 70.3% of households have an internet subscription, respectively.

Community Health Indices

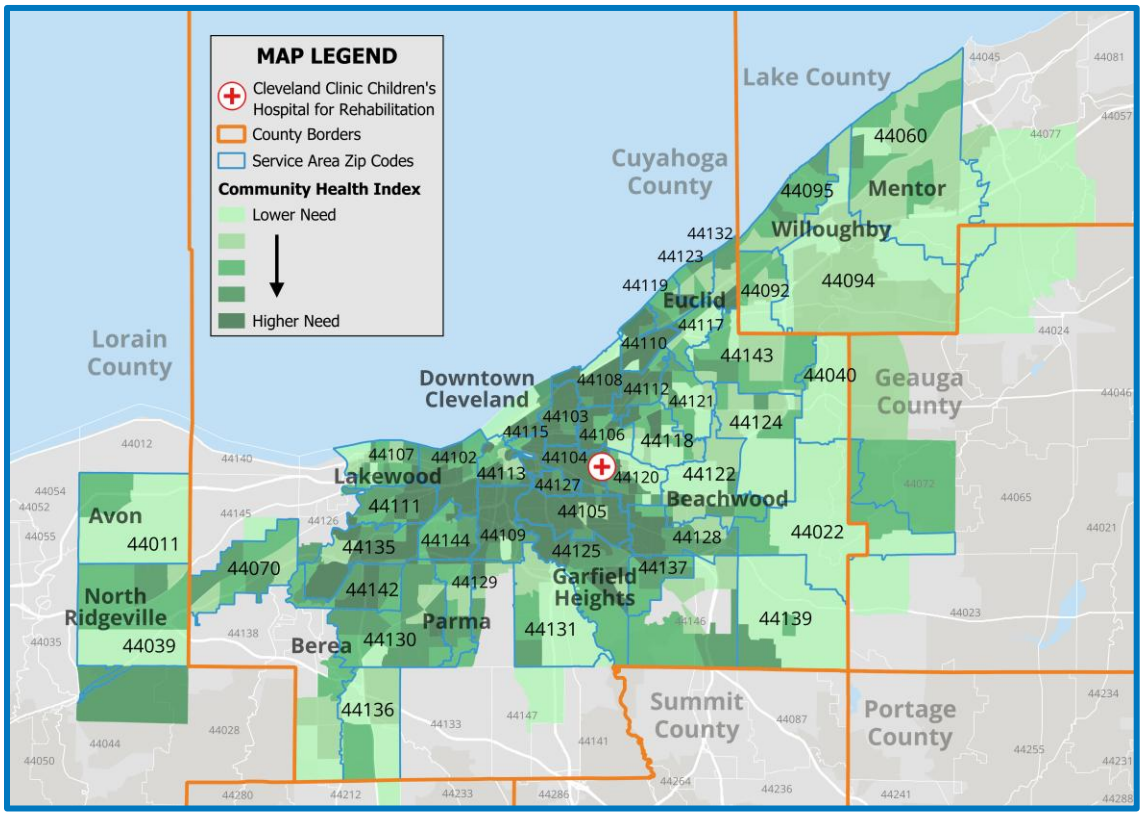
A map index that visualizes social and economic drivers of health at a specific geographic level serves as a critical decision-making tool by highlighting localized differences in health outcomes that may be obscured in broader geographic analyses. The three indices below highlight differences in community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

Community Health Index

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

Figure 6 illustrates which census tracts experience the greatest relative health needs in the CCCHR community, as indicated by the darkest shade of green. At the zip code level, the highest index values are in the zip codes surrounding Downtown Cleveland, including 44115, 44104, 44127, and 44103. See Appendix B for additional details about the CHI and a table of CHI values for each zip code in the community.

Figure 6: Community Health Index by Census Tract, CCCHR Community

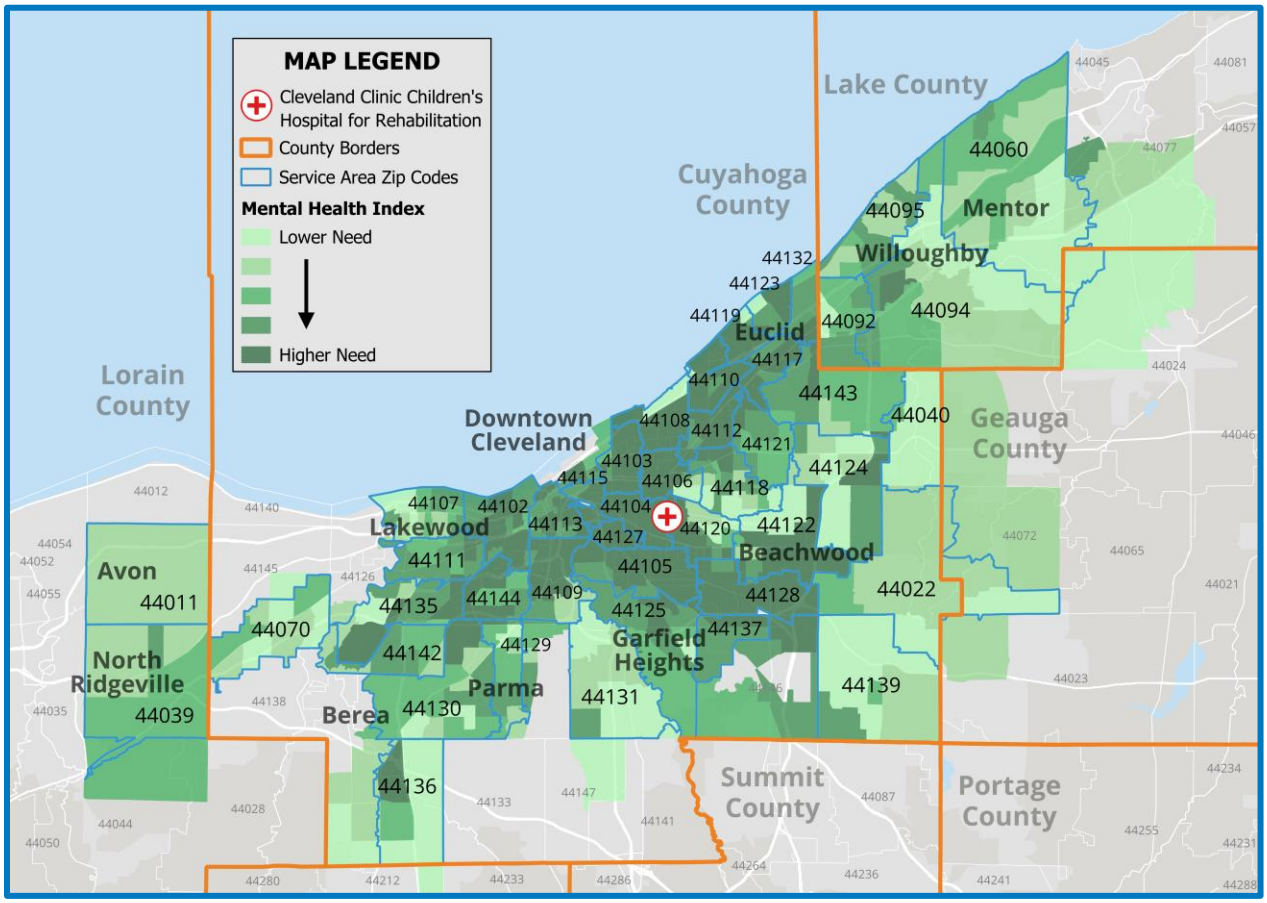


Mental Health Index

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

Figure 7 illustrates which census tracts experience the greatest relative need related to mental health in the CCCHR community, as indicated by the darkest shade of green. More than half of zip codes in the CCCHR community (27 out of 44) have an MHI value greater than 85, indicating widespread mental health challenges across the region. Nine zip codes in particular have a value above 99, including the Cleveland zip codes 44104, 44103, 44108, 44112, 44105, 44110, 44128, and 44115, as well as the Euclid zip code 44117. See Appendix B for additional details about the MHI and a table of MHI values for each zip code in the CCCHR community.

Figure 7: Mental Health Index by Census Tract, CCCHR Community

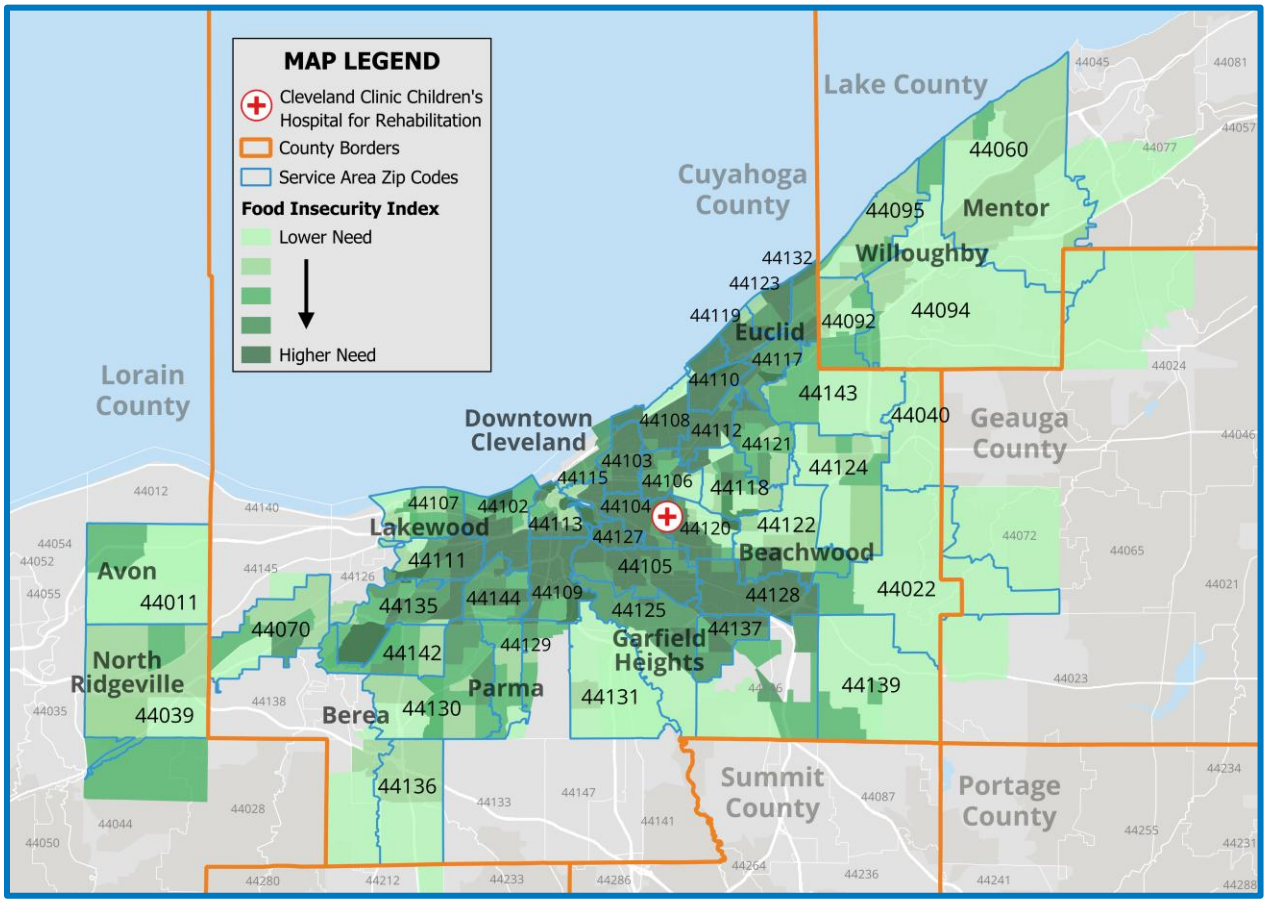


Food Insecurity Index

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

Figure 8 illustrates which census tracts experience the greatest relative need related to food insecurity in the CCCHR community, as indicated by the darkest shade of green. At the zip code level, the highest levels of need are in the Cleveland zip codes 44104, 44115, and 44110, with FII values of 100, 99.9, and 99.0, respectively. See Appendix B for additional details about the FII and a table of FII values for each zip code in the hospital community.

Figure 8: Food Insecurity Index by Census Tract, CCCHR Community



Other Community Assessment and Improvement Plans

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

2023 Ohio State Health Assessment[9]

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

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

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

2023 City of Cleveland Parks and Recreation Community Needs Assessment[10]

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

2024 Cuyahoga County ADAMHS Board Needs Assessment[11]

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

2023 Cuyahoga County Planning Commission Data Book[12]

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

2022 Greater Cleveland LGBTQ+ Community Needs Assessment[13]

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

---

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

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

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

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

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

Joint 2022 Cuyahoga County CHNA (Collaborating Organizations: University Hospital, Cuyahoga County Board of Health, and the City of Cleveland Department of Health)[14]

Priority Health Areas Identified:

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

Prioritized Populations:

- Maternal, Fetal, and Infant Health
- Older Adults

2023 Livable Cuyahoga Needs Assessment[15]

Community & Health Services

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

Outdoor Spaces

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

Transportation

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

Housing

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

---

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

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

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

Social Participation

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

Respect & Engagement

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

Workforce & Civic Engagement

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

2023 United Way of Greater Cleveland Community Needs Assessment[16]

Economic Mobility

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

Health Pathways

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

Housing Stability

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

2022 Lake County Community Health Needs Assessment[17]

Priority Health Areas Identified:

- Access to Health Care
- Behavioral Health (mental health & substance use and misuse)

---

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

[17] Lake County General Health District. (2022). *2022 Lake County, Ohio Community Health Needs Assessment*. Lake County General Health District. https://www.lcghd.org/wp-content/uploads/2022/10/FINAL-2022-Lake-County-Ohio-CHNA-Report_09_30_22.pdf

- Chronic Disease

2025 Lorain County Community Health Needs Assessment[18]

- Financial stability
- Housing
- Food and nutrition
- Health
- Families and children
- Employment

[18] Lorain County Public Health. (2025). *Community Health Assessment* [PDF]. Lorain County. https://www.loraincountyhealth.com/cha

Primary Data Overview

Community Stakeholder Conversations

A total of 14 organizations provided feedback for the CCCHR community. Interviews with each stakeholder varied by individual and the amount of feedback they provided. They generally ranged from thirty to sixty minutes. A full write up of qualitative data findings and the community stakeholder facilitation guide can be found in Appendix D.

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

- ADAMHS Board of Cuyahoga County
- ASIA (Asian Services In Action)
- Boys and Girls Clubs of Northeast Ohio
- City of Cleveland Department of Public Health
- Cleveland Clinic Children's Hospital for Rehabilitation
- Cleveland Clinic Children's
- Cuyahoga County Board of Health
- Cuyahoga Metropolitan Housing Authority
- First Year Cleveland
- Greater Cleveland Food Bank
- Lead Safe Cleveland Coalition
- LGBTQ+ Assessment Greater Cleveland / Cleveland Clinic
- NAMI Greater Cleveland
- Positive Education Program (PEP)

Across stakeholder interviews and supporting data for the 2025 Community Health Needs Assessment, five interconnected priorities emerged for the Cleveland Clinic Children's Hospital for Rehabilitation community: Access to Healthcare, Behavioral Health, Chronic Disease Prevention and Management, Maternal and Child Health, and Health-Related Social Needs. Stakeholders consistently described how these areas overlap and influence one another, emphasizing that many families in the community, particularly those with children with developmental or chronic health needs, face complex barriers to achieving and maintaining good health. Social and economic factors such as poverty, housing instability, and food insecurity were viewed as persistent drivers that limit access to preventive services, timely care, and healthy environments.

Access to Healthcare remains a pressing concern for many residents, especially families managing multiple specialty appointments or long-term therapy services. Stakeholders described how affordability, transportation barriers, and care coordination challenges often delay, or interrupt needed care. Insurance limitations, long wait times, and the shortage of pediatric and rehabilitative providers further complicate access. Participants emphasized that families would benefit from more integrated systems of care and enhanced navigation support to help them manage the complex health and social service networks required for children with special health needs.

Behavioral Health was identified as an escalating challenge across age groups, with particular concern for children and adolescents experiencing anxiety, depression, and behavioral difficulties. Stakeholders described long wait times, high costs, and stigma as major barriers to care, noting that behavioral health services are frequently siloed from medical care. Chronic Disease Prevention and Management was also highlighted as a priority, with diabetes, asthma, and obesity commonly cited as leading health burdens. Stakeholders connected these conditions to food insecurity, poor nutrition, and limited access to safe recreational spaces. Early prevention, consistent follow-up, and family-centered education were described as critical to improving long-term outcomes.

Maternal and Child Health remains central to overall family well-being. Participants pointed to differences in birth outcomes, maternal health conditions, and postpartum supports. Barriers such as transportation, childcare, and limited culturally responsive care contribute to uneven access and poor continuity of maternal and pediatric care.

Finally, Health-Related Social Needs were described as the foundation underlying all other health priorities. Poverty, housing instability, and the high cost of childcare and healthy food create chronic stress for families and reduce capacity to engage in preventive health behaviors. Stakeholders emphasized that meaningful progress requires coordinated, cross-sector partnerships that address both clinical and social influencers of health.

Together, these findings underscore the need for integrated, equal, and family-centered approaches to care within the CCCHR community. Expanding access to affordable healthcare, strengthening behavioral and chronic disease management services, investing in maternal and child supports, and addressing the underlying social and economic barriers to health will be essential to improving outcomes and promoting long-term wellness for children and families across the region.

The following quotes highlight key themes from community feedback.

Priority Area	Key Quote	Additional Context
Access to Healthcare	“Even when families have insurance, getting consistent care is difficult. Appointments take months, and transportation or scheduling issues often mean children miss needed therapies.”	This quote reflects common concerns among stakeholders about the barriers families face in accessing timely, affordable, and coordinated care for children with complex needs. Logistical challenges, such as transportation, availability of appointments, and fragmented systems limit continuity of care and affect rehabilitation outcomes.

Behavioral Health	"There are not enough pediatric behavioral health providers, especially those who understand kids with developmental or physical disabilities."	Stakeholders repeatedly emphasized the shortage of pediatric mental health professionals and the lack of integrated behavioral supports for children with special healthcare needs. This quote underscores the workforce shortages undercutting the need for specialized, developmentally informed behavioral health care within the community.
Chronic Disease Prevention and Management	"Families want to help their kids eat healthy and stay active, but it's hard when food is expensive and neighborhoods don't feel safe for outdoor play."	This statement captures how broader social and environmental conditions such as food insecurity, affordability, and neighborhood safety, affect chronic disease prevention for both children and adults, linking these needs to the region's higher rates of obesity, diabetes, and other preventable chronic conditions.
Maternal and Child Health	"Many moms feel forgotten after giving birth. There's not enough support for mental health, breastfeeding, or navigating care once they go home."	Stakeholders frequently noted gaps in postpartum care and family supports, particularly for women facing social or financial stress. This quote represents the shared concern that while clinical maternity care is strong, ongoing maternal health and early childhood supports remain insufficient and uneven across the community.
Health-Related Social Needs	"When families are worried about rent, food, or transportation, their child's therapy is the first thing to get pushed aside."	This quote succinctly illustrates how economic instability and unmet social needs directly interfere with children's healthcare access and participation in ongoing therapies. It reflects the broader consensus among stakeholders that addressing basic needs is foundational to improving overall health outcomes in the CCCHR community.

Prioritization Methodology

CCCHR's 2025 Community Health Needs Assessment (CHNA) reaffirmed its focus on the same five core health priorities identified in the previous assessment through a comprehensive and data-driven prioritization process. This decision was guided by a rigorous review of primary data, including stakeholder interviews with community leaders

and subject matter experts, alongside secondary data analysis from national, state, and regional sources. An environmental scan further contextualized the findings, providing insight into persistent systemic and community-level challenges. The convergence of qualitative and quantitative findings demonstrated continued challenges in areas such as access to care, behavioral health, chronic disease, and the social drivers of health. Consistent community feedback, coupled with county-level data showing outcomes that continue to exceed state and national benchmarks in these domains, reinforced the need for ongoing, coordinated efforts. As a result, CCCHR has prioritized the same five health needs for its 2026–2028 Implementation Strategy Report, ensuring continuity in addressing longstanding health challenges and advancing improved outcomes for the populations it serves.

Collaborating Organizations

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

Community Partners and Resources

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

Federally Qualified Health Centers and Health Departments

Federally Qualified Health Centers (FQHCs)[19] are community-based clinics that provide comprehensive primary care, behavioral health, and dental services. In Ohio, the Ohio Association of Community Health Centers (OACHC) represents 57 Community Health Centers operating at over 400 locations, including mobile units, and supports access to care through federal funding and enhanced Medicaid and Medicare reimbursement. Within the geography served by CCCHR, community health services are further supported by local public health agencies, including the Cleveland Department of Public Health. The following FQHC clinics and networks operate in the Cleveland Clinic Children's Hospital for Rehabilitation Community:

- Asian Services in Action, Inc.
- Care Alliance
- MetroHealth Community Health Centers (MHCHC)
- Neighborhood Family Practice
- Northeast Ohio Neighborhood Health Services[20]

[19] Ohio Association of Community Health Centers, https://www.ohiochc.org/page/178
[20] Data search August 15, 2022

- Signature Health, Inc.
- The Centers

Hospitals

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

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

Other Community Resources

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

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

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

Comments Received on Previous CHNA

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

Request for Public Comment

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

Appendices Summary

A. CCCHR Community Definition

B. Secondary Data Sources and Analysis

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

C. Environmental Scan and Key Findings

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

D. Community Input Assessment Tools and Key Findings

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

- Key Stakeholder Interview Questions
- Summary Qualitative Findings

E. Impact Evaluation

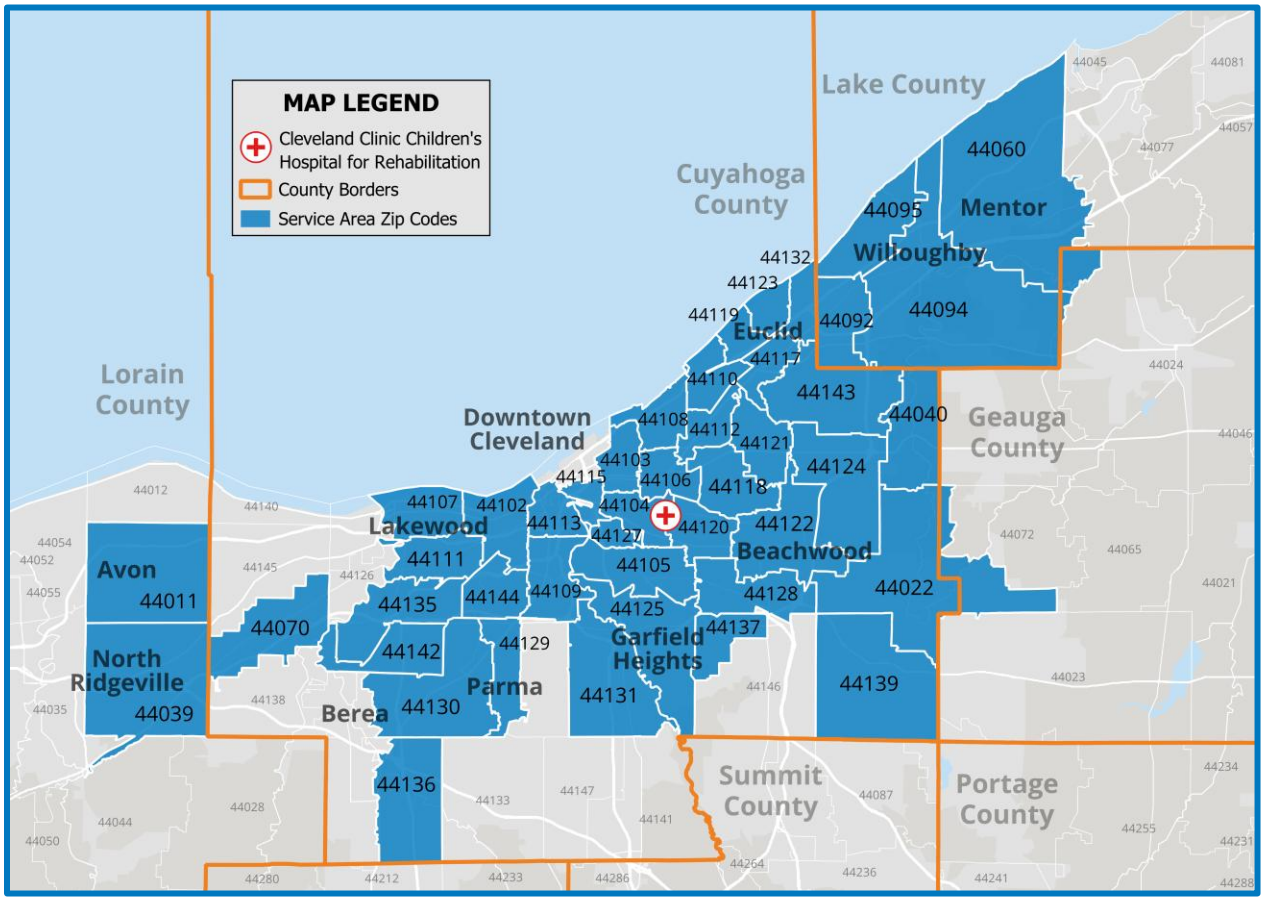
An overview of progress made on the 2022 Implementation Strategies.

F. Acknowledgements

Appendix A: CCCHR Community Definition

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

Figure 9: CCCHR Community Definition



Appendix B: Secondary Data Sources and Analysis

Secondary Data Sources & Analysis

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

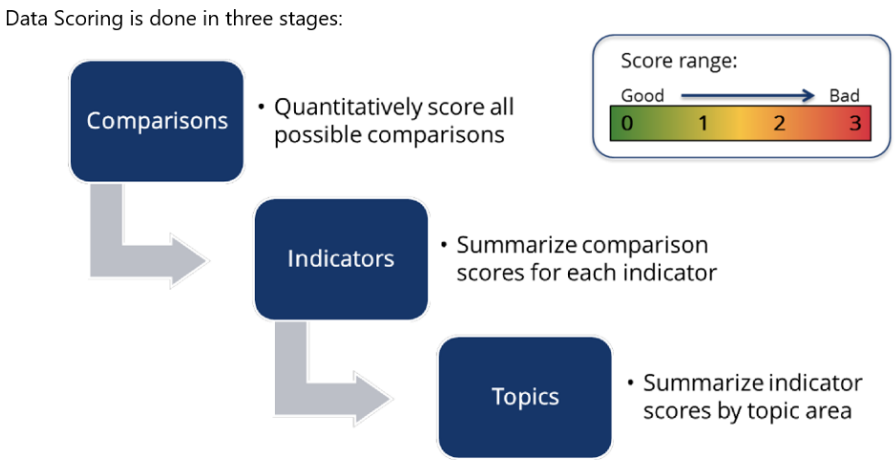
The following is a list of both local and national sources used in the CCCHR Community Health Needs Assessment:

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

Secondary Data Scoring

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

Figure 10: Summary of Topic Scoring Analysis



For the purposes of the CCCHR Community, this analysis was completed for Cuyahoga County, Lake County, and Lorain County. A complete breakdown of topic and indicator scores can be found below.

Comparison to a Distribution of County Values: State and Nation

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

Comparison to Values: State, National, and Targets

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

Trend Over Time

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

Missing Values

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

Indicator Scoring

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

Topic Scoring

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

Figure 11: Health and Quality of Life Topic Areas



Topics that received a score of 1.50 or higher were considered a significant health need. Ten topics scored at or above this threshold across the CCCHR community (see Tables 2 and 3).

Topic Scores

Data from Cuyahoga, Lake, and Lorain counties were scored to calculate county-level topic scores. Each of these topic scores was combined into an overall weighted average score for the CCCHR community. Weights were calculated based on the number of hospital discharges from each county.

Topic Scores: CCCHR Community

Results from the secondary data topic scoring can be seen in Tables 2 and 3 below. The highest scoring health need in the CCCHR community was *Other Chronic Conditions*.

Table 2: Health Topic Scores: CCCHR Community

Health Topic	Score
Other Chronic Conditions	1.86
Sexually Transmitted Infections	1.85
Older Adults	1.60
Family Planning	1.56
Weight Status	1.54
Wellness & Lifestyle	1.52
Children's Health	1.52
Maternal, Fetal & Infant Health	1.48
Nutrition & Healthy Eating	1.46
Diabetes	1.43
Alcohol & Drug Use	1.43
Prevention & Safety	1.40
Cancer	1.37
Adolescent Health	1.33
Mental Health & Mental Disorders	1.30
Heart Disease & Stroke	1.29
Health Care Access & Quality	1.28
Respiratory Diseases	1.23
Immunizations & Infectious Diseases	1.22
Women's Health	1.22
Oral Health	1.18
Tobacco Use	1.06
Physical Activity	1.03

Table 3: Quality of Life Topic Scores: CCCHR Community

Quality of Life Topic	Score
Economy	1.76
Education	1.63
Community	1.51
Environmental Health	1.45

Topic Scores: Cuyahoga County

Results from the secondary data topic scoring can be seen in Tables 4 and 5 below. The highest scoring health need in Cuyahoga County was *Sexually Transmitted Infections*.

Table 4: Health Topic Scores: Cuyahoga County

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

Table 5: Quality of Life Topic Scores: Cuyahoga County

Quality of Life Topic	Score
Economy	1.90
Education	1.72
Community	1.56
Environmental Health	1.46

Topic Scores: Lake County

Results from the secondary data topic scoring can be seen in Tables 6 and 7 below. The highest scoring health need in Lake County was *Other Chronic Conditions*.

Table 6: Health Topic Scores: Lake County

Health Topic	Score
Other Chronic Conditions	1.72
Alcohol & Drug Use	1.56
Older Adults	1.51
Weight Status	1.46
Heart Disease & Stroke	1.45
Cancer	1.43
Women's Health	1.42
Physical Activity	1.35
Diabetes	1.34
Nutrition & Healthy Eating	1.32
Wellness & Lifestyle	1.30
Mental Health & Mental Disorders	1.23
Prevention & Safety	1.23
Respiratory Diseases	1.13
Health Care Access & Quality	1.12
Oral Health	1.11
Immunizations & Infectious Diseases	1.07
Maternal, Fetal & Infant Health	1.07
Tobacco Use	1.01
Sexually Transmitted Infections	0.95
Children's Health	0.79

Table 7: Quality of Life Topic Scores: Lake County

Quality of Life Topic	Score
Community	1.16
Environmental Health	1.14
Economy	1.02
Education	0.99

Topic Scores: Lorain County

Results from the secondary data topic scoring can be seen in Tables 8 and 9 below. The highest scoring health need in Lorain County was *Other Chronic Conditions*.

Table 8: Health Topic Scores: Lorain County

Health Topic	Score
Other Chronic Conditions	2.07
Weight Status	1.89
Older Adults	1.76
Alcohol & Drug Use	1.76
Maternal, Fetal & Infant Health	1.73
Prevention & Safety	1.68
Heart Disease & Stroke	1.65
Women's Health	1.51
Mental Health & Mental Disorders	1.50
Wellness & Lifestyle	1.49
Nutrition & Healthy Eating	1.49
Oral Health	1.42
Respiratory Diseases	1.40
Health Care Access & Quality	1.35
Mortality Data	1.35
Physical Activity	1.33
Cancer	1.31
Diabetes	1.27
Tobacco Use	1.17
Children's Health	1.17
Sexually Transmitted Infections	1.07
Immunizations & Infectious Diseases	0.91

Table 9: Quality of Life Topic Scores: Lorain County

Quality of Life Topic	Score
Community	1.45
Education	1.42
Economy	1.36
Environmental Health	1.28

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 the CCCHR community.

Table 10: Community Health Index, Food Insecurity Index, and Mental Health Index Values for CCCHR Community Zip Codes

Zip Code	CHI Value	FII Value	MHI Value	Zip Code	CHI Value	FII Value	MHI Value
44011	8.9	15.9	38.9	**44117**	23.4	89.1	99.5
44022	6.8	14.5	66.4	**44118**	31.9	62.9	88.6
44039	30.3	37.1	67.5	**44119**	78.8	92.5	97.2
44040	4.9	0.3	25.7	**44120**	57.1	87.9	98.7
44060	23.0	21.9	61.5	**44121**	22.1	79.4	90.9
44070	38.2	40.6	62.9	**44122**	13.3	35.0	90.6
44092	21.7	50.7	76.3	**44123**	55.6	91.9	97.1
44094	11.0	32.3	71.3	**44124**	14.7	29.0	77.7
44095	40.0	36.5	82.6	**44125**	72.3	91.2	94.8
44102	95.9	96.4	98.5	**44127**	99.1	98.4	98.3
44103	98.4	98.6	99.9	**44128**	86.9	97.2	99.7
44104	99.8	100	100	**44129**	46.1	55.7	80.8
44105	96.5	97.7	99.7	**44130**	50.5	54.0	82.6
44106	83.7	82.6	97.6	**44131**	23.6	13.2	42.0
44107	41.2	49.4	77.2	**44132**	66.2	95.6	97.1
44108	96.6	98.0	99.9	**44135**	90.7	92.0	97.4
44109	94.5	93.8	97.9	**44136**	20.0	14.4	59.4
44110	95.0	99.0	99.7	**44137**	72.9	91.2	97.4
44111	86.9	90.5	94.6	**44139**	4.7	12.4	34.5
44112	93.9	97.0	99.9	**44142**	72.6	48.3	84.7
44113	82.0	84.1	91.7	**44143**	19.6	33.0	93.7
44115	99.9	99.9	99.6	**44144**	77.3	83.6	93.2

Census Tract Key

The figures and tables below should serve as a guide for identifying census tracts that are described in various maps throughout this report. Figure 12 and Table 11 show the census tracts for each zip code in the Lake County portion of the CCCHR Community.

Figure 12: Census Tract Key (CCCHR, Lake County)

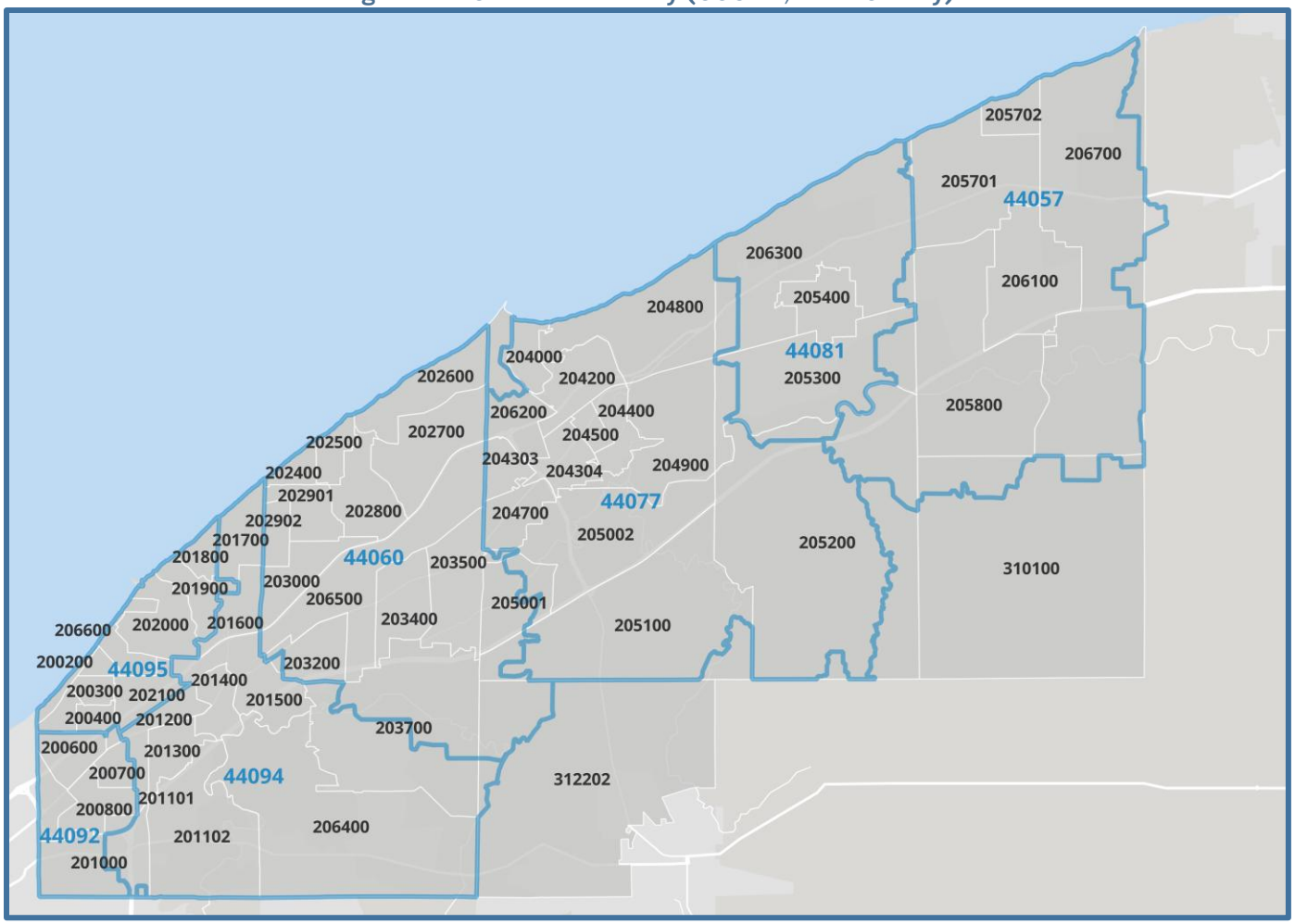


Table 11: Census Tracts by Zip Code (CCCHR, Lake County)

44057	44060	44077	44081	44092	44094	44095
205200	201500	204000	205200	194300	201000	200100
205300	201700	204200	205300	200400	201101	200200
205701	202400	204303	205400	200600	201102	200300
205702	202500	204304	206300	200700	201200	200400
206100	202600	204400		200800	201300	200500
206300	202700	204500		200900	201400	200600
206700	202800	204700		201000	201500	201800
310100	202901	204800			201600	201900
	202902	204900			201700	202000
	203000	205002			201800	202100
	203200	205100			201900	206600
	203400	205200			202901	
	203500	205300			203200	
	203700	206200			203700	
	204700	206300			206400	
	205001				312202	
	205002					
	205100					
	206500					
	312202					

Figure 13 and Table 12 show the census tracts for each zip code in the northern Cuyahoga County portion of the CCCHR Community.

Figure 13: Census Tract Key (CCCHR, Cuyahoga County North)

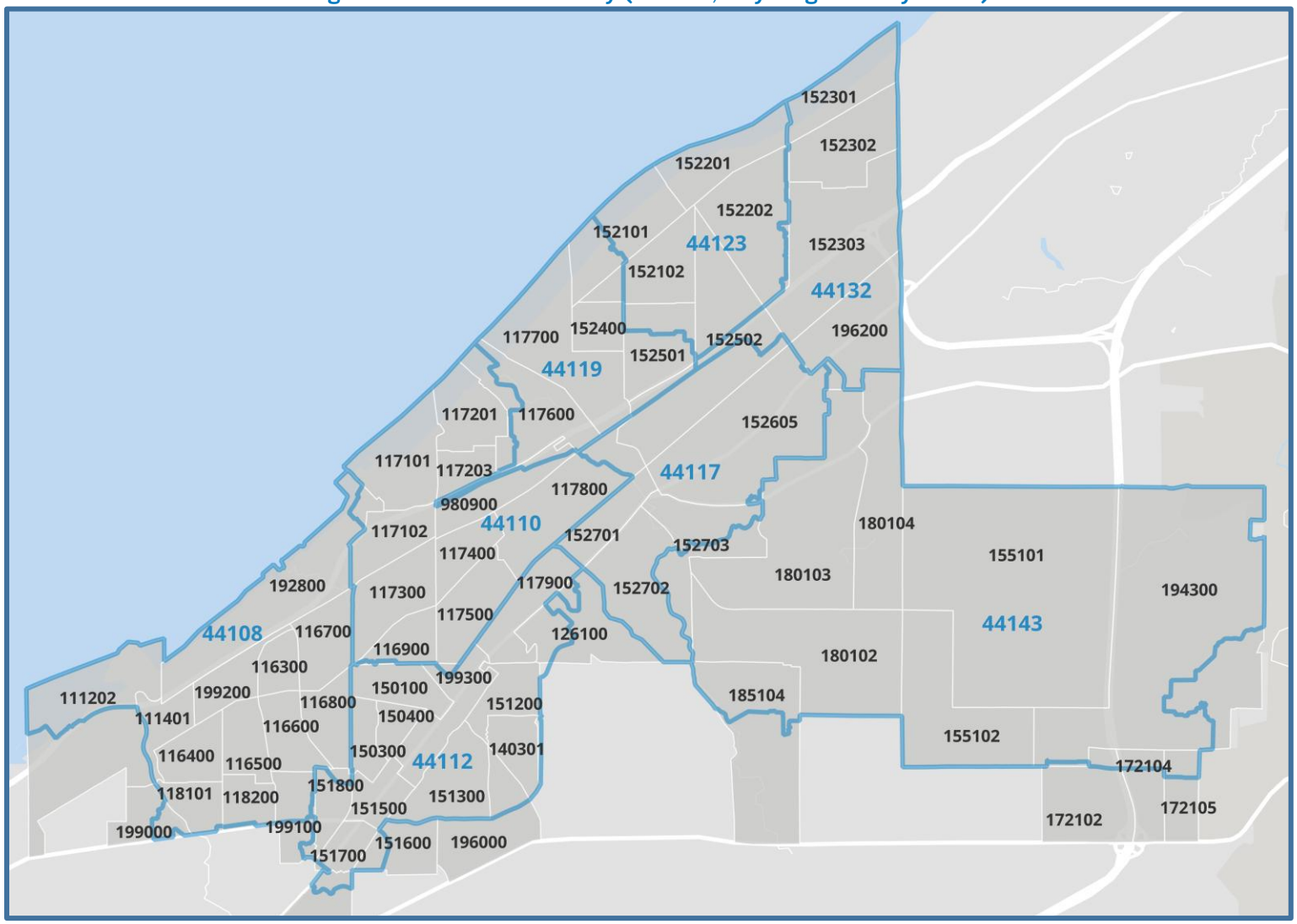


Table 12: Census Tracts by Zip Code (CCCHR, Cuyahoga County North)

44108	44110	44112	44117	44119	44123	44132	44143
111202	116900	116900	117800	117600	152101	152202	152605
111401	117101	117900	152502	117700	152102	152301	152703
116300	117102	118800	152605	152101	152201	152302	155101
116400	117201	126100	152701	152102	152202	152303	155102
116500	117203	140100	152702	152400	152301	152502	172102
116600	117300	140301	152703	152501	152303	152605	172104
116700	117400	140302	180103	152502	152501	196200	172105
116800	117500	150100	196200	980900	152502		180102
118101	117600	150300					180103
118200	117800	150400					180104
150300	192800	151200					185104
151500	199300	151300					194300
151800	980900	151500					196200
192800		151600					201000
199000		151700					
199100		151800					
199200		196000					
		196800					
		199100					
		199300					

Figure 14 and Table 13 show the census tracts for each zip code in the northern Cuyahoga County portion of the CCCHR Community.

Figure 14: Census Tract Key (CCCHR, Cuyahoga County East)

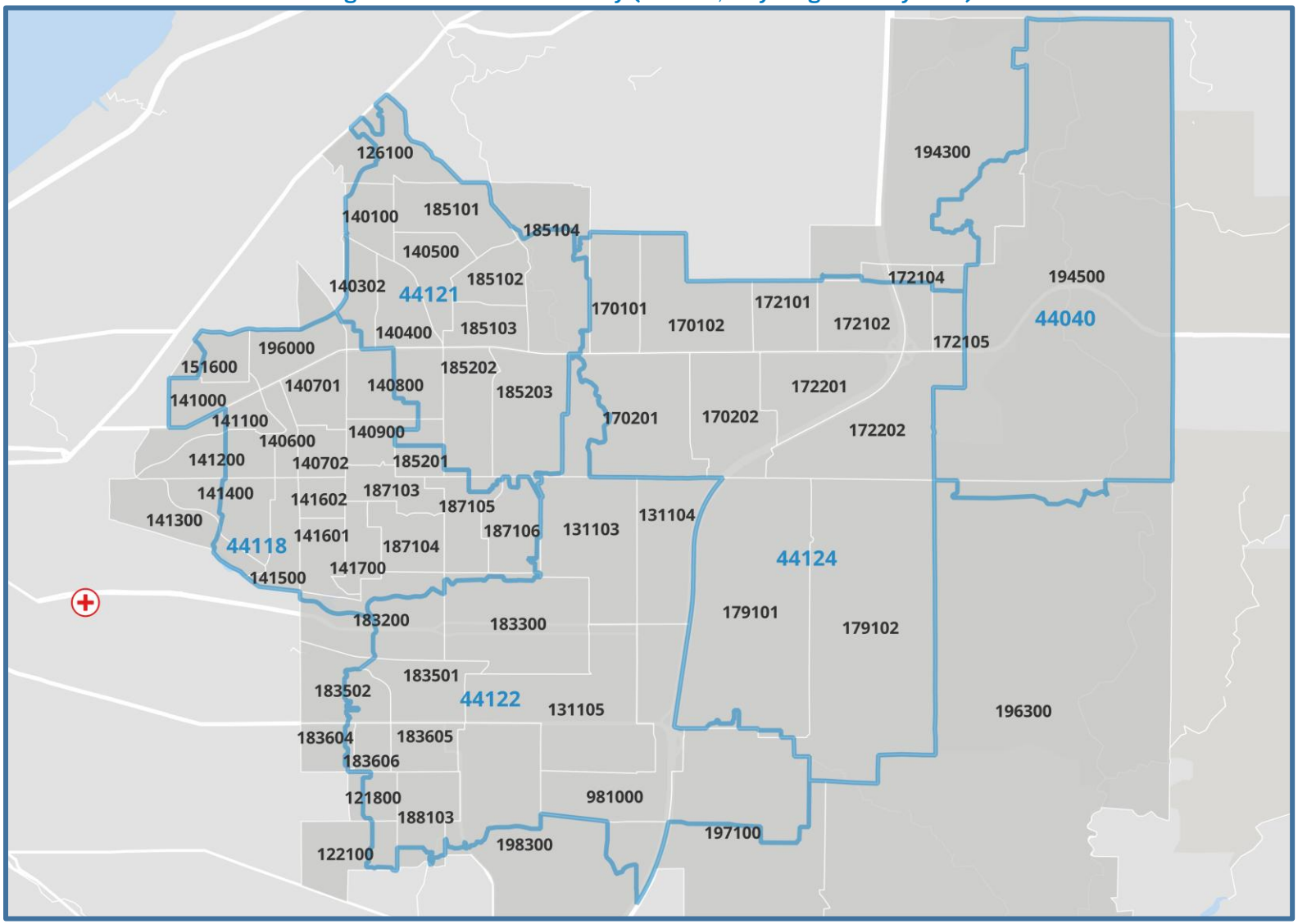


Table 13: Census Tracts by Zip Code (CCCHR, Cuyahoga County East)

44040	44118	44121	44122	44124
194300	140302	117900	121800	131103
194500	140600	126100	122100	155102
196300	140701	140100	131103	170101
310600	140702	140301	131104	170102
	140800	140302	131105	170201
	140900	140400	170201	170202
	141000	140500	179101	172101
	141100	140800	183200	172102
	141200	151200	183300	172104
	141300	170201	183501	172105
	141400	185101	183502	172201
	141500	185102	183604	172202
	141601	185103	183605	179101
	141602	185104	183606	179102
	141700	185201	185203	185104
	151300	185202	187106	194300
	151600	185203	188103	196300
	183200	187105	197100	197100
	183300	187106	198300	
	185201		981000	
	185202			
	187103			
	187104			
	187105			
	187106			
	196000			

Figure 15 and Table 14 show the census tracts for each zip code in the southern Cuyahoga County portion of the CCCHR Community.

Figure 15: Census Tract Key (CCCHR, Cuyahoga County South)

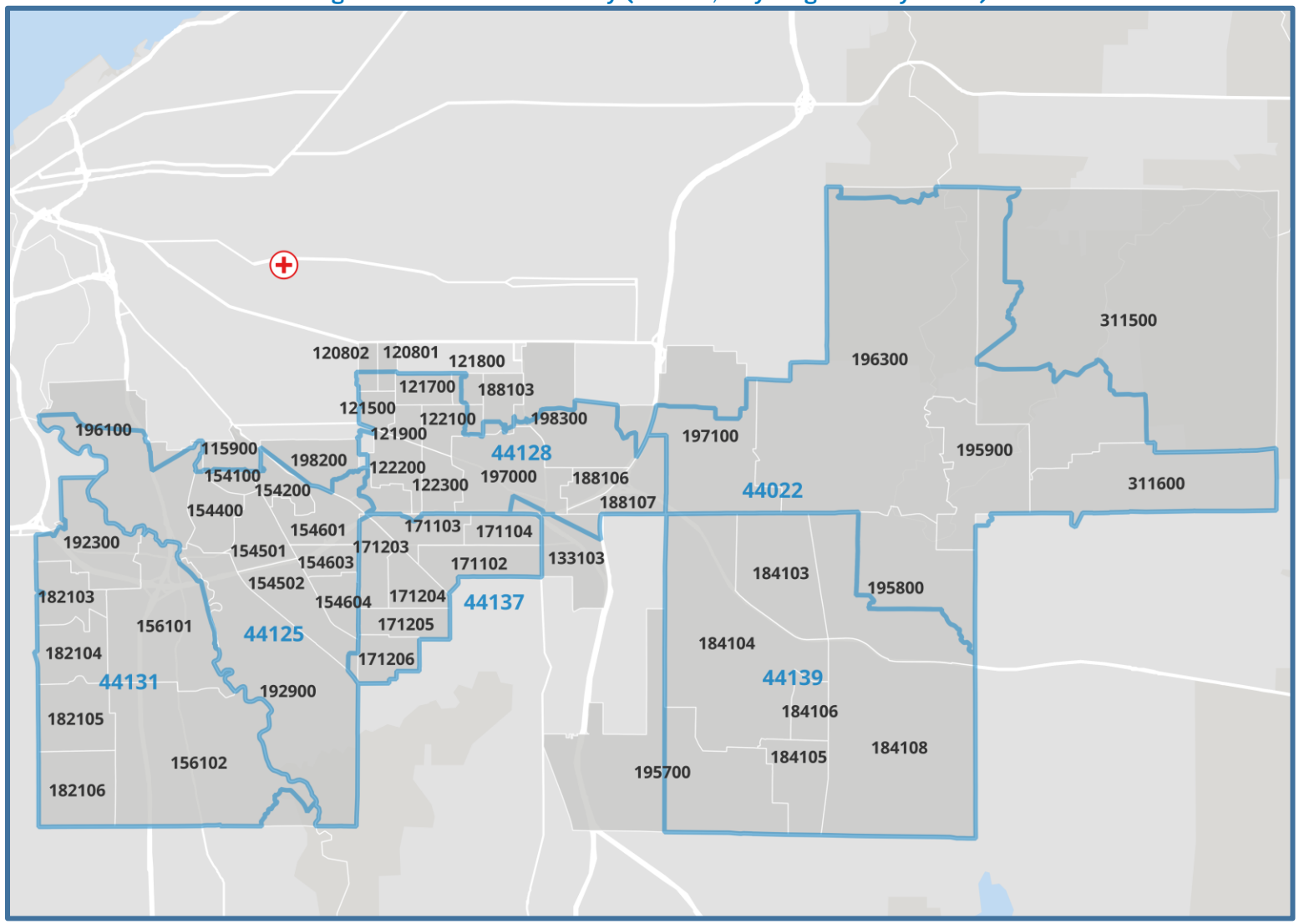


Table 14: Census Tracts by Zip Code (CCCHR, Cuyahoga County South)

44022	44125	44128	44131	44137	44139
179102	115900	120702	107000	132100	184103
195800	154100	120801	136103	132302	184104
195900	154200	120802	156101	154502	184105
196300	154400	121200	156102	154604	184106
197100	154501	121401	182103	171102	184108
310600	154502	121403	182104	171103	195700
311500	154601	121500	182105	171104	195800
311600	154603	121700	182106	171203	
311700	154604	121800	192300	171204	
	156101	121900	192900	171205	
	171103	122100		171206	
	171203	122200			
	192900	122300			
	194100	133103			
	196100	133104			
	198200	171103			
		183603			
		183604			
		188103			
		188106			
		188107			
		197000			
		197100			
		198200			
		198300			

Figure 16 and Table 15 show the census tracts for each zip code in the western Cuyahoga County portion of the CCCHR Community.

Figure 16: Census Tract Key (CCCHR, Cuyahoga County West)

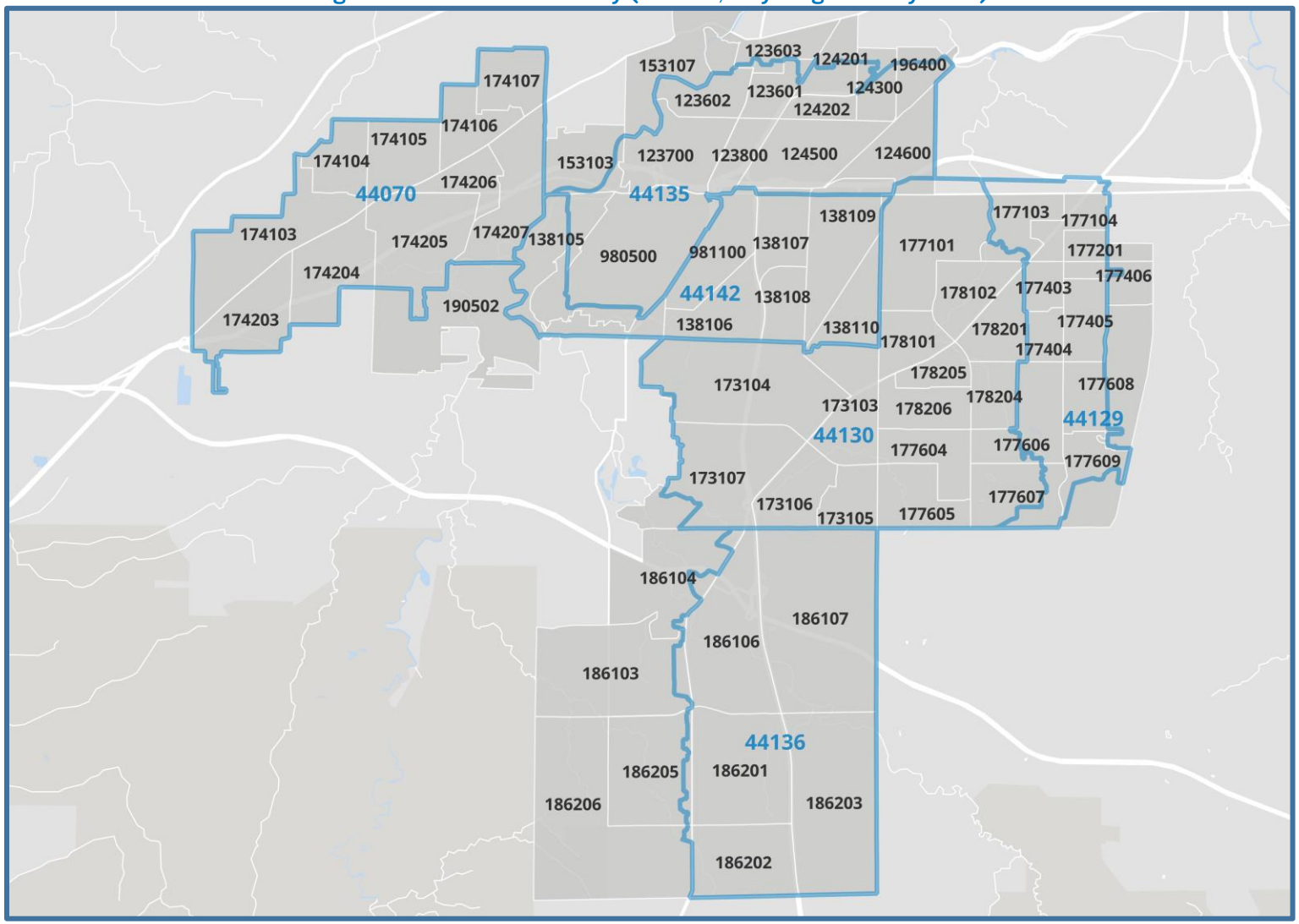


Table 15: Census Tracts by Zip Code (CCCHR, Cuyahoga County West)

44070	44129	44130	44135	44136	44142
174103	106500	124600	123601	186103	138105
174104	106600	137101	123602	186104	138106
174105	137103	137103	123603	186106	138107
174106	177103	173103	123700	186107	138108
174107	177104	173104	123800	186201	138109
174203	177201	173105	124201	186202	138110
174204	177202	173106	124202	186203	177101
174205	177403	173107	124300	186205	980500
174206	177404	177101	124500	186206	981100
174207	177405	177103	124600	415100	
189112	177406	177403	138107		
	177606	177404	138109		
	177607	177604	153103		
	177608	177605	196400		
	177609	177606	980500		
	178201	177607	981100		
	178204	178101			
		178102			
		178201			
		178204			
		178205			
		178206			

Figure 17 and Table 16 show the census tracts for each zip code in the eastern Cleveland portion of the CCCHR Community.

Figure 17: Census Tract Key (CCCHR, East Cleveland)

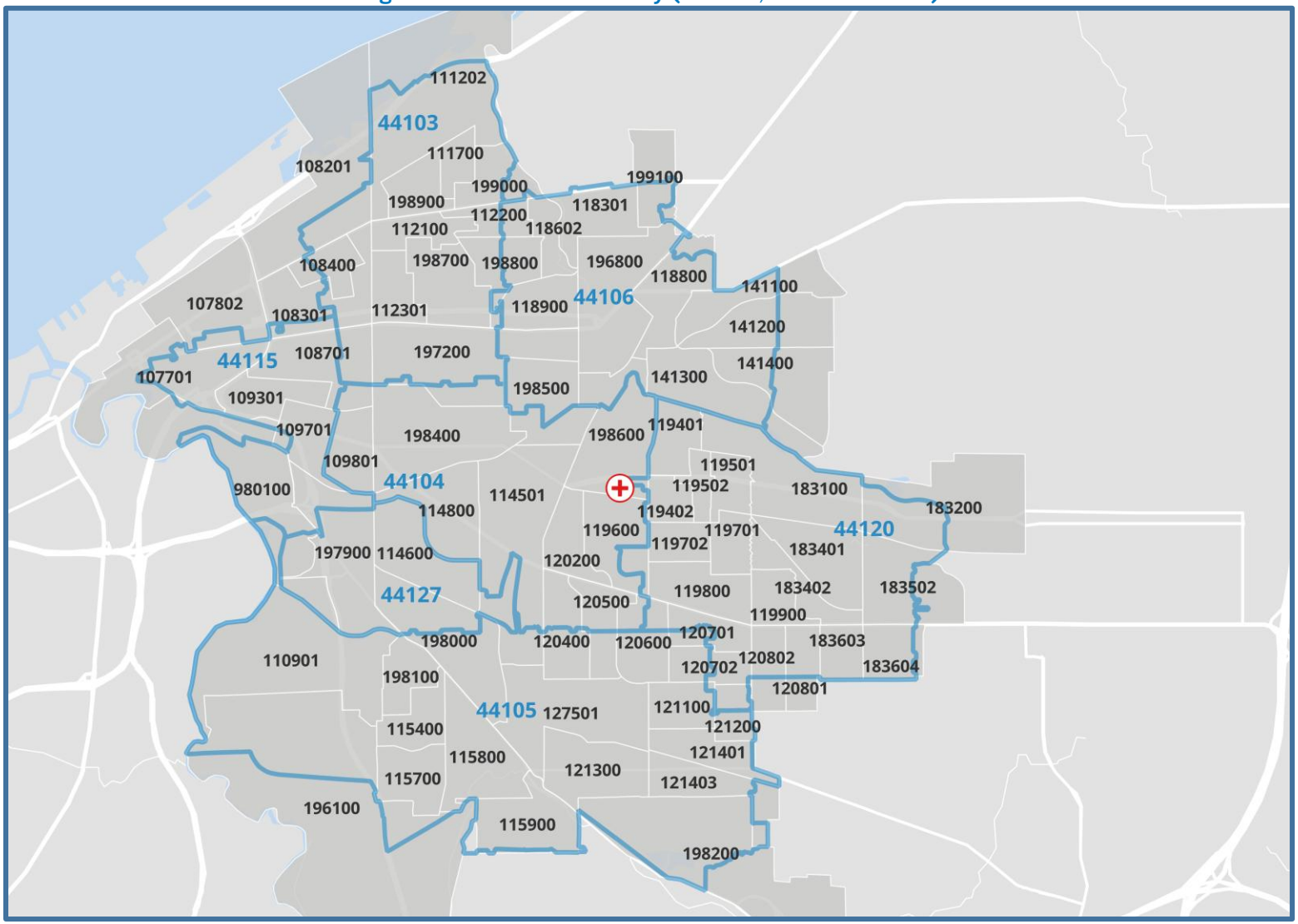


Table 16: Census Tracts by Zip Code (CCCHR, East Cleveland)

44103	44104	44105	44106	44115	44120	44127
108201	108701	110901	112200	109701	119401	114501
108301	109701	114501	118101	109801	119402	114600
108400	109801	115400	118200	107701	119501	197900
108701	114501	115700	118301	109301	119502	198000
111202	114600	115800	118602	197900	119600	980100
111401	114800	115900	118800	132302	119701	
111700	119401	120400	118900	980100	119702	
112100	119600	120500	141000	108301	119800	
112200	120200	120600	141100	108701	119900	
112301	120400	120701	141200	107802	120600	
118900	120500	120702	141300		120701	
154400	120600	121100	141400		120702	
197200	197200	121200	151700		120801	
198500	198400	121300	196800		120802	
198700	198500	121401	197200		121100	
198800	198600	121403	198400		121200	
198900		127501	198500		121700	
199000		154200	198600		183100	
		154400	198800		183200	
		196100	199000		183401	
		198000	199100		183402	
		198100			183502	
		198200			183603	
		980100			183604	
					183605	
					198600	

Figure 18 and Table 17 show the census tracts for each zip code in the western Cleveland portion of the CCCHR Community.

Figure 18: Census Tract Key (CCCHR, West Cleveland)

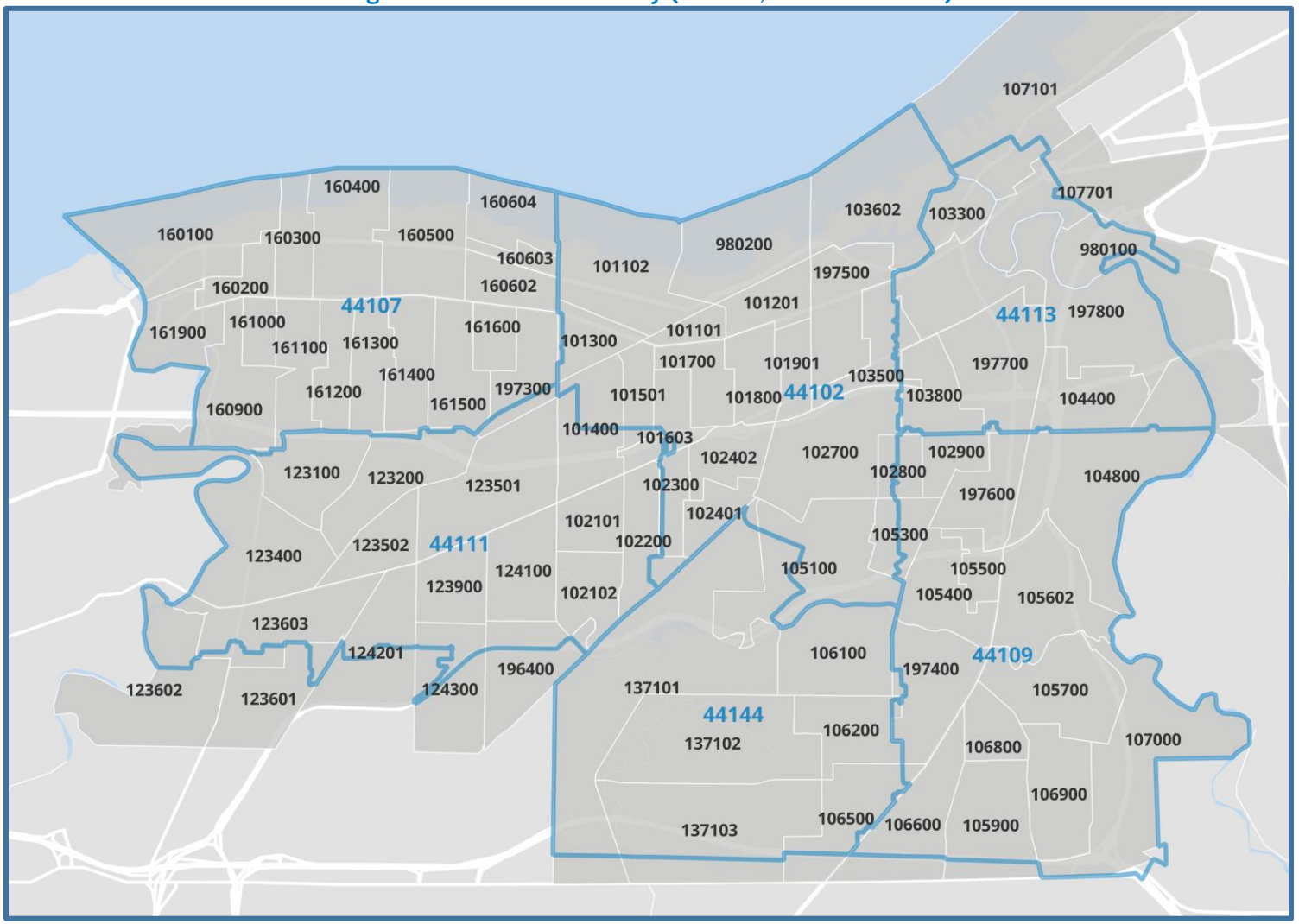


Table 17: Census Tracts by Zip Code (CCCHR, West Cleveland)

44102	44107	44109	44111	44113	44144
101101	101102	102700	101400	102700	105100
101102	101300	102800	101501	103300	106100
101201	123100	102900	101603	103500	106200
101300	123200	103800	102101	103602	106500
101400	123400	104400	102102	103800	137101
101501	160100	104800	102200	104400	137102
101603	160200	105300	102300	104800	137103
101700	160300	105400	123100	107101	197400
101800	160400	105500	123200	107701	
101901	160500	105602	123400	197700	
102200	160602	105700	123501	197800	
102300	160603	105900	123502	980100	
102401	160604	106200	123601		
102402	160900	106500	123602		
102700	161000	106600	123603		
102800	161100	106800	123900		
103500	161200	106900	124100		
103602	161300	107000	124201		
105100	161400	177303	124300		
105300	161500	192300	196400		
137101	161600	196100	197300		
177403	161900	197400			
197500	197300	197600			
980200		197700			

Figure 19 and Table 18 show the census tracts for each zip code in the Lorain County portion of the CCCHR Community.

Figure 19: Census Tract Key (CCCHR, Lorain County)

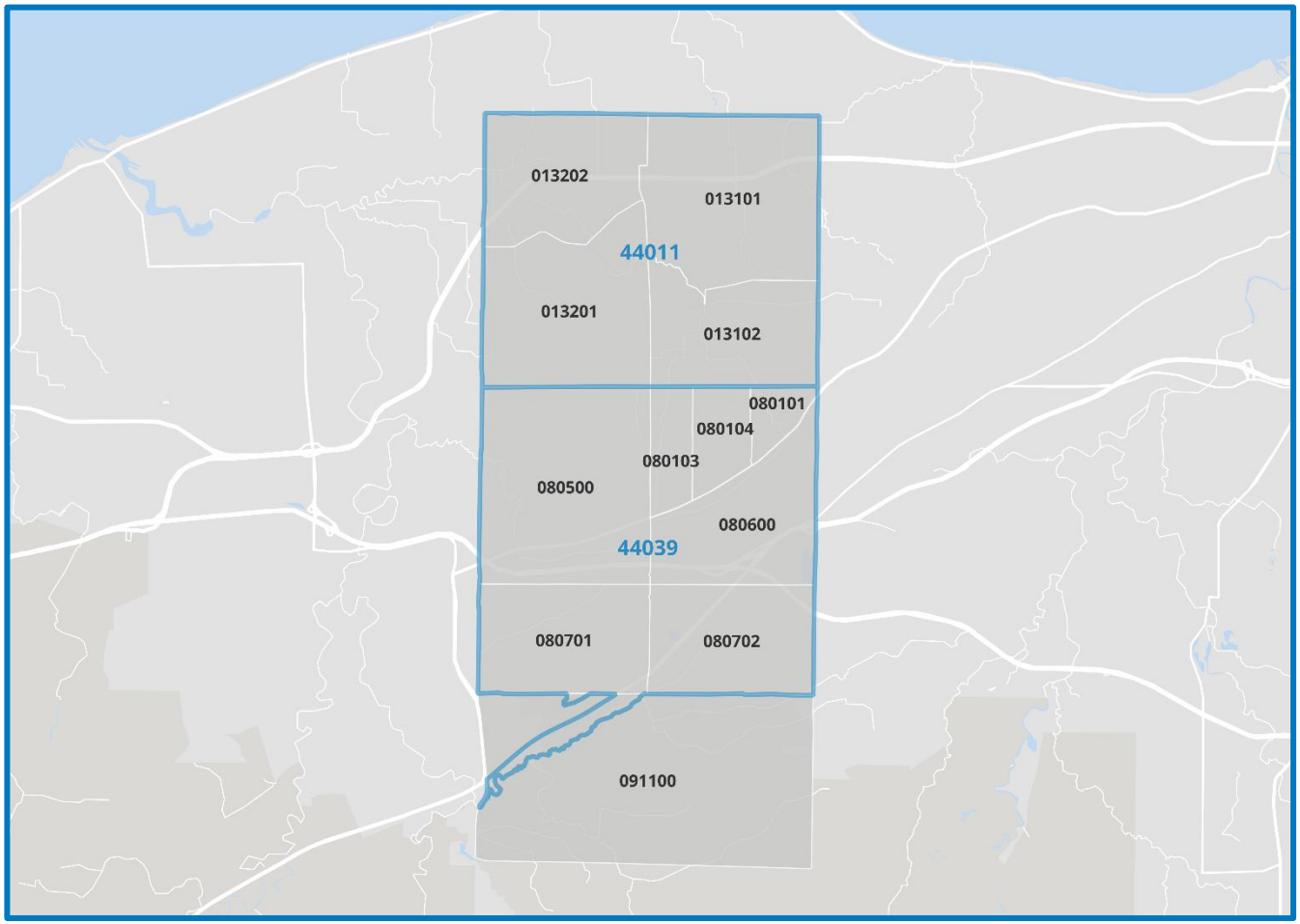


Table 18: Census Tracts by Zip Code (CCCHR, Lorain County)

44011	44039
013101	080101
013102	080103
013201	080104
013202	080500
	080600
	080701
	080702
	091100

Community Health Index (CHI)

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

HOW IS THE INDEX VALUE CALCULATED?

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

WHAT DO THE RANKS AND COLORS MEAN?

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

Food Insecurity Index (FII)

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

HOW IS THE INDEX VALUE CALCULATED?

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

WHAT DO THE RANKS AND COLORS MEAN?

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

Mental Health Index (MHI)

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

HOW IS THE INDEX VALUE CALCULATED?

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

WHAT DO THE RANKS AND COLORS MEAN?

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

Data Considerations

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

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

Race or Ethnic and Special Population Groupings

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

Zip Codes and Zip Code Tabulation Areas

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

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

Indicators of Concern for Prioritized Health Needs

Below are details regarding indicators of concern for all prioritized health needs discussed in this report. Each indicator includes a county-level value and standardized score, as well as the following comparison data, where available: state value, national value, state county distribution, national county distribution, and over-time trend. Table 20 describes how to interpret the icons used to describe county distributions and trend data.

Table 19: 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.

Cuyahoga County Indicators of Concern

Access to Healthcare: Cuyahoga County

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

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

Behavioral Health: Cuyahoga County

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

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

Chronic Disease Prevention and Management: Cuyahoga County

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

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

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

Maternal and Child Health: Cuyahoga County

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

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

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

Health-Related Social Needs: Cuyahoga County

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

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

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

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

Lake County Indicators of Concern

Access to Healthcare: Lake County

The topic *Health Care Access and Quality* was ranked as the sixteenth highest scoring health need, with a score of 1.12 out of 3. Those indicators scoring at or above 1.00 were categorized as indicators of concern.

SCORE	INDICATOR	UNITS	LAKE COUNTY	HP2030	OH	U.S.	OH Counties	U.S. Counties	Trend
2.35	Primary Care Provider Rate	*providers/ 100,000 population*	41.4	--	75.3	74.9			
2.21	Preventable Hospital Stays: Medicare Population	*discharges/ 100,000 Medicare enrollees*	3544.0	--	3269.0	2769.0			--
1.35	Health Insurance Spending-to-Income Ratio	*percent*	6.5	--	6.6	5.9			
1.32	Non-Physician Primary Care Provider Rate	*providers/ 100,000 population*	93.2	--	148.7				
1.29	Adults with Health Insurance: 18+	*percent*	76.9	--	74.7	75.2			
1.12	Dentist Rate	*dentists/ 100,000 population*	67.3	--	65.2	73.5			
1.06	Adults who have had a Routine Checkup	*percent*	79.1	--		76.1			--

Behavioral Health: Lake County

The prioritized health topic *Behavioral Health* was captured under three health topic areas: *Mental Health and Mental Disorders*, *Alcohol and Drug Use*, and *Tobacco Use*. The most concerning of these topics was *Alcohol and Drug Use* (Score: 1.56), followed by *Mental Health and Mental Disorders* (1.23), and the least concerning was *Tobacco Use* (1.01). Indicators from these three topic areas which scored at or above 1.50 were categorized as indicators of concern.

SCORE	INDICATOR	UNITS	LAKE COUNTY	HP2030	OH	U.S.	OH Counties	U.S. Counties	Trend
2.44	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	50.0	--	32.1	--			
2.03	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate	*Deaths per 100,000 population*	39.4	--	40.4	23.5			--
2.00	Age-Adjusted Death Rate due to Suicide	*deaths/ 100,000 population*	16.8	12.8	14.5	--			
1.74	Poor Mental Health: Average Number of Days	*days*	6.1	--	6.1	--			
1.59	Adults Ever Diagnosed with Depression	*percent*	24.7	--	--	20.7			--
1.59	Poor Mental Health: 14+ Days	*percent*	17.7	--	--	15.8			--
1.59	Adults who Binge Drink	*percent*	17.1	--	--	16.6			--

Chronic Disease Prevention and Management: Lake County

The prioritized health topic *Chronic Disease Prevention and Management* was captured under the following health topics: *Nutrition and Healthy Eating*, *Wellness and Lifestyle*, *Cancer*, *Diabetes*, *Heart Disease and Stroke*, *Other Chronic Conditions*, and *Older Adults*. The most concerning of these topics was *Other Chronic Conditions* (Score: 1.72), followed by *Older Adults* (1.51), *Heart Disease and Stroke* (1.45), *Cancer* (1.43), *Diabetes* (1.34), *Nutrition and Healthy Eating* (1.32), and the least concerning topic was *Wellness and Lifestyle* (1.30). Indicators from these seven topic areas which scored at or above 1.70 were categorized as indicators of concern.

SCORE	INDICATOR	UNITS	LAKE COUNTY	HP2030	OH	U.S.	OH Counties	U.S. Counties	Trend
2.82	People 65+ Living Alone	*percent*	30.9	--	30.2	26.5			
2.74	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	10.6	--	7.8	7.5	--		
2.47	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	21.1	--	12.1	--			
2.38	Osteoporosis: Medicare Population	*percent*	13.0	--	11.0	12.0			--
2.38	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	40.0	--	39.0	36.0			--
2.35	Breast Cancer Incidence Rate	*cases/ 100,000 females*	141.9	--	132.3	129.8			
2.21	Hyperlipidemia: Medicare Population	*percent*	70.0	--	67.0	66.0			--
2.12	Adults with Cancer (Non-Skin) or Melanoma	*percent*	9.8	--	--	8.2			--
2.12	Prostate Cancer Incidence Rate	*cases/ 100,000 males*	114.2	--	118.1	113.2			
2.00	All Cancer Incidence Rate	*cases/ 100,000 population*	488.5	--	470.0	444.4			

1.94	Adults with Arthritis	*percent*	33.4	--	--	26.6			--
1.94	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	*deaths/ 100,000 population*	43.9	33.4	46.0	--			
1.94	People 65+ Living Alone (Count)	*people*	15103	--	--	--	--	--	
1.94	People 65+ Living Below Poverty Level (Count)	*people*	3438	--	--	--	--	--	
1.85	Adults who Frequently Cook Meals at Home	*Percent*	67.7	--	67.6	67.7			--
1.85	Stroke: Medicare Population	*percent*	6.0	--	5.0	6.0			--
1.82	Age-Adjusted Death Rate due to Prostate Cancer	*deaths/ 100,000 males*	19.7	16.9	19.3	19.0	--		
1.76	Adults who Experienced Coronary Heart Disease	*percent*	8.7	--	--	6.8			--
1.76	Insufficient Sleep	*percent*	38.9	26.7	--	36.0			--

Maternal and Child Health: Lake County

The prioritized health topic *Maternal and Child Health* was captured under two health topic areas: *Maternal, Fetal, and Infant Health* and *Children's Health*. The more concerning of these topics was *Maternal, Fetal, and Infant Health*, with a score of 1.07, followed by *Children's Health*, with a score of 0.79. Indicators from these topic areas which scored at or above 1.00 were categorized as indicators of concern.

SCORE	INDICATOR	UNITS	LAKE COUNTY	HP2030	OH	U.S.	OH Counties	U.S. Counties	Trend
1.65	Preterm Births	*percent*	10.6	9.4	10.8	--		--	--
1.26	Mothers who Received Early Prenatal Care	*percent*	70.2	--	68.6	75.3		--	
1.09	Mothers who Smoked During Pregnancy	*percent*	5.8	4.3	7.9	3.7		--	
1.06	Child Care Centers	*per 1,000 population under age 5*	8.2	--	8.0	7.0		--	--
1.03	Babies with Low Birthweight	*percent*	7.6	--	8.7	8.6		--	
1.00	Babies with Very Low Birthweight	*percent*	1.0	--	1.5	--		--	

Health-Related Social Needs: Lake County

The prioritized health topic *Health-Related Social Needs* was captured under the quality of life topics *Community, Economy,* and Education, as well as the health topic *Prevention and Safety*. The topic *Prevention and Safety* was the fourteenth highest scoring health topic with a score of 1.23. The most concerning quality of life topic was *Community* (Score: 1.16), followed by *Economy* (1.02), and the least concerning topic was *Education* (0.99). Indicators from these four health and quality of life topic areas which scored at or above 1.50 were categorized as indicators of concern.

SCORE	INDICATOR	UNITS	LAKE COUNTY	HP2030	OH	U.S.	OH Counties	U.S. Counties	Trend
2.82	People 65+ Living Alone	*percent*	30.9	--	30.2	26.5			
2.71	Workers who Walk to Work	*percent*	1.1	--	2.0	2.4			
2.65	Median Monthly Owner Costs for Households without a Mortgage	*dollars*	620	--	570	612			
2.53	Student-to-Teacher Ratio	*students/ teacher*	18.0	--	16.6	15.2			
2.53	Total Employment Change	*percent*	0.9	--	2.9	5.8			
2.47	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	21.1	--	12.1	--			
2.44	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	50.0	--	32.1	--			
2.38	Grandparents Who Are Responsible for Their Grandchildren	*percent*	42.4	--	41.3	32.0		--	

2.29	Median Household Gross Rent	*dollars*	1073	--	988	1348			
2.26	Social Associations	*membership associations/ 10,000 population*	8.5	--	10.8	--			
2.12	Renters Spending 30% or More of Household Income on Rent	*percent*	46.0	25.5	45.1	50.4			
2.06	Homeowner Spending-to-Income Ratio	*percent*	14.5	--	14.3	13.5			
2.06	Youth not in School or Working	*percent*	2.2	--	1.7	1.7			
1.94	Mortgaged Owners Median Monthly Household Costs	*dollars*	1472	--	1472	1902			
1.94	People 65+ Living Alone (Count)	*people*	15103	--	--	--	--	--	
1.94	People 65+ Living Below Poverty Level (Count)	*people*	3438	--	--	--	--	--	
1.76	Death Rate due to Injuries	*deaths/ 100,000 population*	102.2	--	100.7	--			--
1.68	Linguistic Isolation	*percent*	1.6	--	1.5	4.2			
1.65	Children in Single-Parent Households	*percent*	24.7	--	26.1	24.8			

1.65	Workers Commuting by Public Transportation	*percent*	0.6	5.3	1.1	3.5		--	
1.50	High School Graduation	*percent*	93.6	90.7	92.5	--		--	
1.50	Households that are Asset Limited, Income Constrained, Employed (ALICE)	*percent*	24.7	--	25.0	29.4		--	

Lorain County Indicators of Concern

Access to Healthcare: Lorain County

The topic *Health Care Access and Quality* was ranked as the fourteenth highest scoring health need, with a score of 1.35 out of 3. Those indicators scoring at or above 1.50 were categorized as indicators of concern and are listed in the table below.

SCORE	INDICATOR	UNITS	LORAIN COUNTY	HP2030	OH	U.S.	OH Counties	U.S. Counties	Trend
2.29	Primary Care Provider Rate	*providers/ 100,000 population*	51.6	--	75.3	74.9			
2.03	Preventable Hospital Stays: Medicare Population	*discharges/ 100,000 Medicare enrollees*	3494	--	3269	2769			--
1.85	Dentist Rate	*dentists/ 100,000 population*	49.0	--	65.2	73.5			
1.71	Health Insurance Spending-to-Income Ratio	*Percent*	6.8	--	6.6	5.9			
1.50	Adults With Group Health Insurance	*Percent*	37.3	--	37.4	39.8			--

Behavioral Health: Lorain County

The prioritized health topic *Behavioral Health* was captured under three health topic areas: *Mental Health and Mental Disorders*, *Alcohol and Drug Use*, and *Tobacco Use*. The most concerning of these topics was *Alcohol and Drug Use* (Score: 1.76), followed by *Mental Health and Mental Disorders* (1.50), and the least concerning was *Tobacco Use* (1.17). Indicators from these three topic areas which scored at or above 1.50 were categorized as indicators of concern and are listed in the table below.

SCORE	INDICATOR	UNITS	LORAIN COUNTY	HP2030	OH	U.S.	OH Counties	U.S. Counties	Trend
2.29	Adults Ever Diagnosed with Depression	*percent*	27.6	--	--	20.7			--
2.21	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate	*Deaths per 100,000 population*	42.1	--	40.4	23.5			--
2.15	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	37.3	--	32.1	--			
2.12	Poor Mental Health: 14+ Days	*percent*	19.6	--	--	15.8			--
2.09	Poor Mental Health: Average Number of Days	*days*	6.3	--	6.1	--			
1.94	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	45.5	20.7	44.7	--			--
1.76	Adults who Binge Drink	*percent*	18.1	--	--	16.6			--
1.76	Adults who Smoke	*percent*	18.7	6.1	--	12.9			--
1.74	Adults who Drink Excessively	*percent*	20.9	--	21.2	--			
1.68	Age-Adjusted Death Rate due to Suicide	*deaths/ 100,000 population*	15.4	12.8	14.7	13.9			
1.68	Depression: Medicare Population	*percent*	18	--	18	17			--
1.53	Cigarette Spending-to-Income Ratio	*percent*	2.1	--	2.1	1.9			

Chronic Disease Prevention and Management: Lorain County

The prioritized health topic *Chronic Disease Prevention and Management* was captured under the following health topics: *Nutrition and Healthy Eating*, *Wellness and Lifestyle*, *Cancer*, *Diabetes*, *Heart Disease and Stroke*, *Other Chronic Conditions*, and *Older Adults*. The most concerning of these topics was *Other Chronic Conditions* (Score: 2.07), followed by *Older Adults* (1.76), *Heart Disease and Stroke* (1.65), *Wellness and Lifestyle* (1.49), *Nutrition and Healthy Eating* (1.49), *Cancer* (1.31), and the least concerning topic was *Diabetes* (1.27). Indicators from these seven topic areas which scored at or above 1.50 were categorized as indicators of concern and are listed in the table below.

SCORE	INDICATOR	UNITS	LORAIN COUNTY	HP2030	OH	U.S.	OH Counties	U.S. Counties	Trend
2.82	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	14.6	--	10.8	9.8			
2.56	Chronic Kidney Disease: Medicare Population	*percent*	23	--	19	18			--
2.56	Ischemic Heart Disease: Medicare Population	*percent*	25	--	22	21			--
2.56	Stroke: Medicare Population	*percent*	7	--	5	6			--
2.53	Breast Cancer Incidence Rate	*cases/ 100,000 females*	142.9	--	132.3	129.8			
2.38	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	42	--	39	36			--
2.35	Prostate Cancer Incidence Rate	*cases/ 100,000 males*	124.7	--	118.1	113.2			
2.35	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	22	15.3	20.2	19.3			
2.21	Atrial Fibrillation: Medicare Population	*percent*	16	--	15	14			--
2.21	COPD: Medicare Population	*percent*	15	--	13	11			--
2.21	Hyperlipidemia: Medicare Population	*percent*	71	--	67	66			--

2.12	People 65+ Living Below Poverty Level	*percent*	10.3	--	9.5	10.4			
2.03	Adults who Frequently Cook Meals at Home	*Percent*	67.3	--	67.6	67.7			--
2.00	All Cancer Incidence Rate	*cases/ 100,000 population*	487.6	--	470.0	444.4			
2.00	People 65+ Living Alone	*percent*	29.9	--	30.2	26.5			
1.94	People 65+ Living Alone (Count)	*people*	18231	--	--	--	--	--	
1.94	People 65+ Living Below Poverty Level (Count)	*people*	6116	--	--	--	--	--	
1.94	High Blood Pressure Prevalence	*percent*	38.2	41.9	--	32.7			--
1.94	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	*deaths/ 100,000 population*	40.5	33.4	43.4	37.6			
1.85	Hypertension: Medicare Population	*percent*	70	--	67	65			--
1.85	Osteoporosis: Medicare Population	*percent*	12	--	11	12			--
1.85	Adults Happy with Weight	*Percent*	41.9	--	42.1	42.6			--
1.82	Age-Adjusted Death Rate due to Kidney Disease	*deaths/ 100,000 population*	14.2	--	14.2	12.8			
1.82	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	13.3	--	12.8	12.0			
1.76	Adults with Arthritis	*percent*	31.7	--	--	26.6			--
1.76	Adults who Experienced Coronary Heart Disease	*percent*	8.5	--	--	6.8			--

1.76	Self-Reported General Health Assessment: Poor or Fair	*percent*	20.7	--	--	17.9			--
1.76	Poor Physical Health: 14+ Days	*percent*	14.7	--	--	12.7			--
1.68	Depression: Medicare Population	*percent*	18	--	18	17			--
1.59	Adults with Cancer (Non-Skin) or Melanoma	*percent*	9.2	--	--	8.2			--
1.56	Food Environment Index	--	7.6	--	7.0	--			
1.50	Asthma: Medicare Population	*percent*	7	--	7	7			--
1.50	Cancer: Medicare Population	*percent*	12	--	12	12			--

Maternal and Child Health: Lorain County

The prioritized health topic *Maternal and Child Health* was captured under two health topic areas: *Maternal, Fetal, and Infant Health* and *Children's Health*. The most concerning of these topics was *Maternal, Fetal, and Infant Health*, with a score of 1.73, followed by *Children's Health*, with a score of 1.17. Indicators from these topic areas which scored at or above 1.50 were categorized as indicators of concern and are listed in the table below.

SCORE	INDICATOR	UNITS	LORAIN COUNTY	HP2030	OH	U.S.	OH Counties	U.S. Counties	Trend
2.74	Babies with Low Birthweight	*percent*	9.7	--	8.7	8.6		--	
2.18	Babies with Very Low Birthweight	*percent*	1.8	--	1.5	--		--	
2.18	Preterm Births	*percent*	12.4	9.4	10.8	--		--	
1.62	Infant Mortality Rate	*deaths/ 1,000 live births*	6.3	5.0	6.7	5.4	--	--	

Health-Related Social Needs: Lake County

The prioritized health topic *Health-Related Social Needs* was captured under the quality of life topics *Community, Economy,* and Education, as well as the health topic *Prevention and Safety*. The topic *Prevention and Safety* was the sixth highest scoring health topic with a score of 1.68. The most concerning quality of life topic was *Community* (Score: 1.45), followed by *Education* (1.42), and the least concerning topic was *Economy* (1.36). Indicators from these four health and quality of life topic areas which scored at or above 1.50 were categorized as indicators of concern and are listed in the table below.

SCORE	INDICATOR	UNITS	LORAIN COUNTY	HP2030	OH	U.S.	OH Counties	U.S. Counties	Trend
2.82	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	14.6	--	10.8	9.8			
2.65	Median Monthly Owner Costs for Households without a Mortgage	*dollars*	615	--	570	612			
2.41	Households with Cash Public Assistance Income	*percent*	3.1	--	2.5	2.7			
2.35	Age-Adjusted Death Rate due to Unintentional Poisonings	*deaths/ 100,000 population*	42.1	--	40.5	23.5			
2.35	Student-to-Teacher Ratio	*students/ teacher*	17.1	--	16.6	15.2			
2.24	Homeowner Spending-to-Income Ratio	*percent*	15.0	--	14.3	13.5			
2.12	Households that are Above the Asset Limited, Income Constrained, Employed (ALICE) Threshold	*percent*	59.9	--	61.0	--		--	
2.12	Households that are Asset Limited, Income Constrained, Employed (ALICE)	*percent*	27.1	--	25.0	--		--	
2.12	Mortgaged Owners Median Monthly Household Costs	*dollars*	1495	--	1472	1902			
2.12	People 65+ Living Below Poverty Level	*percent*	10.3	--	9.5	10.4			
2.09	Severe Housing Problems	*percent*	12.9	--	12.7	--			

2.06	Young Children Living Below Poverty Level	*percent*	23.3	--	20.0	17.6			
1.94	People 65+ Living Below Poverty Level (Count)	*people*	6116	--	--	--	--	--	
1.94	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	45.5	20.7	44.7	--			--
1.88	Children Living Below Poverty Level	*percent*	18.8	--	18.0	16.3			
1.88	Unemployed Veterans	*percent*	3.5	--	2.8	3.2			
1.85	Income Inequality	--	0.5	--	0.5	0.5			
1.85	High School Graduation	*percent*	90.8	90.7	92.5	--		--	
1.82	Food Insecurity Rate	*percent*	15.4	--	15.3	14.5			
1.76	Median Household Gross Rent	*dollars*	916	--	988	1348			
1.76	Death Rate due to Injuries	*deaths/ 100,000 population*	101.7	--	100.7	--			--
1.71	Health Insurance Spending-to-Income Ratio	*percent*	6.8	--	6.6	5.9			
1.71	Age-Adjusted Death Rate due to Unintentional Injuries	*deaths/ 100,000 population*	69.9	43.2	69.9	51.6			
1.71	Day Care Center and Preschool Spending-to-Income Ratio	*percent*	7.2	--	7.4	7.1			
1.68	Households Spending 50% or More of Household Income on Housing	*percent*	12.1	--	11.5	14.3			--
1.53	4th Grade Students Proficient in English/Language Arts	*percent*	63.0	--	64.1	--		--	

1.53	Cigarette Spending-to-Income Ratio	*percent*	2.1	--	2.1	1.9			
1.53	College Tuition Spending-to-Income Ratio	*percent*	12.3	--	12.6	11.9			
1.53	Renters Spending 30% or More of Household Income on Rent	*percent*	46.3	25.5	45.1	50.4			
1.53	Utilities Spending-to-Income Ratio	*percent*	6.2	--	6.1	5.6			

All Indicator Scores by Topic Area

Below we have included tables of all indicators that were scored as part of the secondary data analysis for Cuyahoga, Lake, and Lorain counties. Indicators are grouped under their respective health and quality of life topic areas.

Cuyahoga County Indicator Scores

Table 21 includes all indicators that were scored as part of the Cuyahoga County secondary data analysis. Refer to Table 20 to identify each indicator's data source.

Table 20: 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 Dept. of Health, Infectious Diseases
18	Ohio Dept. of Health, Vital Statistics
19	Ohio Dept. of Health's Ohio Healthy Homes Lead Poisoning Prevention Program
20	Ohio Dept. of Public Safety, Office of Criminal Justice Services
21	Ohio Public Health Information Warehouse
22	Ohio Secretary of State
23	Prevention Research Center for Healthy Neighborhoods
24	Purdue Center for Regional Development
25	The Ohio Pregnancy Assessment Survey (OPAS) Dashboard
26	U.S. Bureau of Labor Statistics
27	U.S. Census - County Business Patterns
28	U.S. Census Bureau - Small Area Health Insurance Estimates
29	U.S. Environmental Protection Agency
30	United For ALICE

Table 21: All Cuyahoga County Secondary Data Indicators

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Lake County Indicator Scores

Table 23 includes all indicators that were scored as part of the Lake County secondary data analysis. Refer to Table 22 to identify each indicator's data source.

Table 22: 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	Feeding America
12	National Cancer Institute
13	National Center for Education Statistics
14	National Environmental Public Health Tracking Network
15	Ohio Department of Education
16	Ohio Department of Health, Infectious Diseases
17	Ohio Department of Health, Vital Statistics
18	Ohio Department of Public Safety, Office of Criminal Justice Services
19	Ohio Public Health Information Warehouse
20	Ohio Secretary of State
21	Purdue Center for Regional Development
22	U.S. Bureau of Labor Statistics
23	U.S. Census - County Business Patterns
24	U.S. Census Bureau - Small Area Health Insurance Estimates
25	U.S. Environmental Protection Agency
26	United For ALICE

Table 23: All Lake County Secondary Data Indicators

SCORE	ALCOHOL & DRUG USE	UNITS	LAKE COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.44	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	50.0		32.1		*2018-2022*	10
2.03	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate	*Deaths per 100,000 population*	39.4		40.4	23.5	*2018-2020*	6
1.59	Adults who Binge Drink	*percent*	17.1			16.6	*2022*	5
1.38	Adults who Drink Excessively	*percent*	19.8		21.2		*2022*	10
1.24	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	38.2	20.7	44.7		*2020-2022*	10
1.15	Liquor Store Density	*stores/ 100,000 population*	6.5		5.6	10.9	*2022*	23
1.09	Mothers who Smoked During Pregnancy	*percent*	5.8	4.3	7.9	3.7	*2022*	17

SCORE	CANCER	UNITS	LAKE COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.74	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	10.6		7.8	7.5	*2017-2021*	12
2.35	Breast Cancer Incidence Rate	*cases/ 100,000 females*	141.9		132.3	129.8	*2017-2021*	12
2.12	Adults with Cancer (Non-Skin) or Melanoma	*percent*	9.8			8.2	*2022*	5
2.12	Prostate Cancer Incidence Rate	*cases/ 100,000 males*	114.2		118.1	113.2	*2017-2021*	12

2.00	All Cancer Incidence Rate	*cases/ 100,000 population*	488.5		470.0	444.4	*2017-2021*	12
1.82	Age-Adjusted Death Rate due to Prostate Cancer	*deaths/ 100,000 males*	19.7	16.9	19.3	19.0	*2018-2022*	12
1.53	Age-Adjusted Death Rate due to Colorectal Cancer	*deaths/ 100,000 population*	14.3	8.9	13.9	12.9	*2018-2022*	12
1.53	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	63.8		64.3	53.1	*2017-2021*	12
1.50	Cancer: Medicare Population	*percent*	12.0		12.0	12.0	*2023*	7
1.32	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	12.3		12.8	12.0	*2017-2021*	12
0.97	Mammography Screening: Medicare Population	*percent*	51.0		51.0	39.0	*2023*	7
0.88	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	37.4	25.1	39.8	32.4	*2018-2022*	12
0.88	Cervical Cancer Screening: 21-65	*Percent*	82.8			82.8	*2020*	5
0.88	Colon Cancer Screening: USPSTF Recommendation	*percent*	67.4			66.3	*2022*	5
0.88	Mammogram in Past 2 Years: 50-74	*percent*	78.2	80.3		76.5	*2022*	5
0.82	Colorectal Cancer Incidence Rate	*cases/ 100,000 population*	35.3		38.9	36.4	*2017-2021*	12
0.71	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	18.2	15.3	20.2	19.3	*2018-2022*	12
0.71	Age-Adjusted Death Rate due to Cancer	*deaths/ 100,000 population*	155.3	122.7	161.1	146.0	*2018-2022*	12

SCORE	CHILDREN'S HEALTH	UNITS	LAKE COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
1.06	Child Care Centers	*per 1,000 population under age 5*	8.2		8.0	7.0	*2022*	10

0.94	Child Food Insecurity Rate	*percent*	16.2		20.1	18.4	*2023*	11
0.91	Children with Health Insurance	*percent*	97.8		95.1	94.6	*2023*	1
0.82	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	0.6		1.9		*2022*	19
0.82	Substantiated Child Abuse Rate	*cases/ 1,000 children*	3.8	8.7	6.9		*2021*	4
0.71	Child Mortality Rate: Under 20	*deaths/ 100,000 population under 20*	39.2		59.2		*2019-2022*	10
0.29	Home Child Care Spending-to-Income Ratio	*percent*	2.7		3.2	3.3	*2025*	9

SCORE	COMMUNITY	UNITS	LAKE COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.82	People 65+ Living Alone	*percent*	30.9		30.2	26.5	*2019-2023*	2
2.71	Workers who Walk to Work	*percent*	1.1		2.0	2.4	*2019-2023*	2
2.65	Median Monthly Owner Costs for Households without a Mortgage	*dollars*	620		570	612	*2019-2023*	2
2.53	Total Employment Change	*percent*	0.9		2.9	5.8	*2021-2022*	23
2.44	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	50.0		32.1		*2018-2022*	10
2.38	Grandparents Who Are Responsible for Their Grandchildren	*percent*	42.4		41.3	32.0	*2019-2023*	2
2.29	Median Household Gross Rent	*dollars*	1073		988	1348	*2019-2023*	2
2.26	Social Associations	*membership associations/*	8.5		10.8		*2022*	10

		10,000 population						
2.06	Youth not in School or Working	*percent*	2.2		1.7	1.7	*2019-2023*	2
1.94	Mortgaged Owners Median Monthly Household Costs	*dollars*	1472		1472	1902	*2019-2023*	2
1.94	People 65+ Living Alone (Count)	*people*	15103				*2019-2023*	2
1.68	Linguistic Isolation	*percent*	1.6		1.5	4.2	*2019-2023*	2
1.65	Children in Single-Parent Households	*percent*	24.7		26.1	24.8	*2019-2023*	2
1.65	Workers Commuting by Public Transportation	*percent*	0.6	5.3	1.1	3.5	*2019-2023*	2
1.29	Adults with Internet Access	*percent*	82.0		80.9	81.3	*2024*	8
1.18	Day Care Center and Preschool Spending-to-Income Ratio	*percent*	6.6		7.4	7.1	*2025*	9
1.09	Residential Segregation - Black/White	*Score*	53.0		69.6		*2025*	10
1.06	Workers who Drive Alone to Work	*percent*	77.9		76.6	70.2	*2019-2023*	2
1.00	Adult Day Care Spending-to-Income Ratio	*percent*	10.2		11.1	11.9	*2025*	9
1.00	Violent Crime Rate	*crimes/ 100,000 population*	140.9		331.0		*2024*	18
1.00	Voter Turnout: Presidential Election	*percent*	78.6	58.4	71.7		*2024*	20
0.97	Adults Who Vote in Presidential Elections: Always or Sometimes	*percent*	86.8		84.9	85.1	*2024*	8
0.97	Adults With Group Health Insurance	*percent*	39.5		37.4	39.8	*2024*	8
0.97	Digital Distress		1.0				*2022*	21
0.97	Social Vulnerability Index	*Score*	0.1				*2022*	6

0.97	Solo Drivers with a Long Commute	*percent*	31.3		30.5		*2019-2023*	10
0.88	People 25+ with a Bachelor's Degree or Higher	*percent*	30.5		30.9	35.0	*2019-2023*	2
0.85	Age-Adjusted Death Rate due to Firearms	*deaths/ 100,000 population*	7.7	10.7	13.5	12.0	*2018-2020*	6
0.82	Mean Travel Time to Work	*minutes*	23.3		23.6	26.6	*2019-2023*	2
0.82	Substantiated Child Abuse Rate	*cases/ 1,000 children*	3.8	8.7	6.9		*2021*	4
0.79	Adults With Individual Health Insurance	*percent*	22.0		20.5	20.2	*2024*	8
0.74	Persons with Health Insurance	*percent*	93.8	92.4	92.9		*2022*	24
0.71	Death Rate due to Motor Vehicle Collisions	*deaths/ 100,000 population*	6.9		11.1		*2016-2022*	10
0.71	Households with a Smartphone	*percent*	88.3		87.5	88.2	*2024*	8
0.65	Female Population 16+ in Civilian Labor Force	*percent*	61.3		59.2	58.7	*2019-2023*	2
0.65	Gasoline and Other Fuels Spending-to-Income Ratio	*percent*	3.0		3.3	3.1	*2025*	9
0.65	Households with a Computer	*percent*	87.5		85.2	86.0	*2024*	8
0.59	People Living Below Poverty Level	*percent*	8.2	8.0	13.2	12.4	*2019-2023*	2
0.53	Households with One or More Types of Computing Devices	*percent*	94.6		93.6	94.8	*2019-2023*	2
0.53	Per Capita Income	*dollars*	43197		39455	43289	*2019-2023*	2
0.44	Broadband Quality Score	*BQS Score*	65.9		53.4	50.0	*2022*	21
0.44	Digital Divide Index	*DDI Score*	15.0		40.1	50.0	*2022*	21

0.35	Households with an Internet Subscription	*percent*	91.9		89.0	89.9	*2019-2023*	2
0.35	Median Household Income	*dollars*	77952		69680	78538	*2019-2023*	2
0.35	People 25+ with a High School Diploma or Higher	*percent*	93.9		91.6	89.4	*2019-2023*	2
0.35	Persons with an Internet Subscription	*percent*	94.0		91.3	92.0	*2019-2023*	2
0.35	Population 16+ in Civilian Labor Force	*percent*	62.7		60.1	59.8	*2019-2023*	2
0.29	Children Living Below Poverty Level	*percent*	11.5		18.0	16.3	*2019-2023*	2
0.29	Young Children Living Below Poverty Level	*percent*	9.7		20.0	17.6	*2019-2023*	2

SCORE	DIABETES	UNITS	LAKE COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
1.65	Adults 20+ with Diabetes	*percent*	8.8				*2021*	6
1.41	Age-Adjusted Death Rate due to Diabetes	*deaths/ 100,000 population*	22.2		28.4		*2020-2022*	19
0.97	Diabetes: Medicare Population	*percent*	24.0		25.0	24.0	*2023*	7

SCORE	ECONOMY	UNITS	LAKE COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.65	Median Monthly Owner Costs for Households without a Mortgage	*dollars*	620		570	612	*2019-2023*	2
2.53	Total Employment Change	*percent*	0.9		2.9	5.8	*2021-2022*	23
2.29	Median Household Gross Rent	*dollars*	1073		988	1348	*2019-2023*	2
2.12	Renters Spending 30% or More of Household Income on Rent	*percent*	46.0	25.5	45.1	50.4	*2019-2023*	2
2.06	Homeowner Spending-to-Income Ratio	*percent*	14.5		14.3	13.5	*2025*	9

2.06	Youth not in School or Working	*percent*	2.2	1.7	1.7	*2019-2023*	2
1.94	Mortgaged Owners Median Monthly Household Costs	*dollars*	1472	1472	1902	*2019-2023*	2
1.94	People 65+ Living Below Poverty Level (Count)	*people*	3438			*2019-2023*	2
1.50	Households that are Asset Limited, Income Constrained, Employed (ALICE)	*percent*	24.7	25.0	29.4	*2023*	26
1.47	Unemployed Workers in Civilian Labor Force	*percent*	4.9	5.4	4.5	*April 2025*	22
1.35	Health Insurance Spending-to-Income Ratio	*percent*	6.5	6.6	5.9	*2025*	9
1.35	Home Renter Spending-to-Income Ratio	*percent*	15.5	16.3	17.0	*2025*	9
1.35	Size of Labor Force	*persons*	124299			*Apr-25*	22
1.26	Children Living Below 200% of Poverty Level	*percent*	35.8	38.3	36.1	*2023*	1
1.24	Households with Cash Public Assistance Income	*percent*	2.1	2.5	2.7	*2019-2023*	2
1.21	Households that are Above the Asset Limited, Income Constrained, Employed (ALICE) Threshold	*percent*	65.5	61.5	58.0	*2023*	26
1.18	Day Care Center and Preschool Spending-to-Income Ratio	*percent*	6.6	7.4	7.1	*2025*	9
1.18	Households with Student Loan Debt	*percent*	8.8	9.1	9.8	*2024*	8
1.09	Gender Pay Gap	*cents on the dollar*	0.8	0.7	0.8	*2023*	1
1.09	Residential Segregation - Black/White	*Score*	53.0	69.6		*2025*	10
1.03	Families Living Below 200% of Poverty Level	*Percent*	19.3	22.8	22.3	*2023*	1

1.03	People 65+ Living Below 200% of Poverty Level	*percent*	23.2		28.4	28.1	*2023*	1
1.03	People Living Below 200% of Poverty Level	*percent*	24.8		29.6	28.2	*2023*	1
1.00	Adult Day Care Spending-to-Income Ratio	*percent*	10.2		11.1	11.9	*2025*	9
1.00	Cigarette Spending-to-Income Ratio	*percent*	2.0		2.1	1.9	*2025*	9
1.00	College Tuition Spending-to-Income Ratio	*percent*	11.2		12.6	11.9	*2025*	9
1.00	Utilities Spending-to-Income Ratio	*percent*	5.7		6.1	5.6	*2025*	9
0.97	Income Inequality		0.4		0.5	0.5	*2019-2023*	2
0.94	Child Food Insecurity Rate	*percent*	16.2		20.1	18.4	*2023*	11
0.94	Food Insecurity Rate	*percent*	13.4		15.3	14.5	*2023*	11
0.88	Mortgaged Owners Spending 30% or More of Household Income on Housing	*percent*	20.1	25.5	21.2	28.5	*2023*	1
0.88	People 65+ Living Below Poverty Level	*percent*	7.2		9.5	10.4	*2019-2023*	2
0.88	Unemployed Veterans	*percent*	2.7		2.8	3.2	*2019-2023*	2
0.85	Households Living Below Poverty Level	*percent*	9.8		13.5	12.7	*2023*	26
0.82	Households with a 401k Plan	*percent*	40.7		38.4	40.8	*2024*	8
0.82	Students Eligible for the Free Lunch Program	*percent*	24.6		23.6	43.6	*2023-2024*	13
0.82	Vocational, Technical, and Other School Tuition Spending-to-Income Ratio	*percent*	1.4		1.6	1.5	*2025*	9

0.79	Adults who Feel Overwhelmed by Financial Burdens	*percent*	31.8		34.0	33.6	*2024*	8
0.76	Adults with Disability Living in Poverty	*percent*	21.2		28.2	24.6	*2019-2023*	2
0.76	Overcrowded Households	*percent*	1.2		1.4	3.4	*2019-2023*	2
0.71	Median Household Income: Householders 65+	*dollars*	54575		51608	57108	*2019-2023*	2
0.65	Female Population 16+ in Civilian Labor Force	*percent*	61.3		59.2	58.7	*2019-2023*	2
0.65	Gasoline and Other Fuels Spending-to-Income Ratio	*percent*	3.0		3.3	3.1	*2025*	9
0.65	Households with a Savings Account	*percent*	74.2		70.9	72.0	*2024*	8
0.59	Families Living Below Poverty Level	*percent*	5.2		9.2	8.7	*2019-2023*	2
0.59	People Living Below Poverty Level	*percent*	8.2	8.0	13.2	12.4	*2019-2023*	2
0.53	Per Capita Income	*dollars*	43197		39455	43289	*2019-2023*	2
0.44	Severe Housing Problems	*percent*	9.5		12.7		*2017-2021*	10
0.35	Median Household Income	*dollars*	77952		69680	78538	*2019-2023*	2
0.35	Population 16+ in Civilian Labor Force	*percent*	62.7		60.1	59.8	*2019-2023*	2
0.29	Children Living Below Poverty Level	*percent*	11.5		18.0	16.3	*2019-2023*	2
0.29	Home Child Care Spending-to-Income Ratio	*percent*	2.7		3.2	3.3	*2025*	9
0.29	Student Loan Spending-to-Income Ratio	*percent*	4.0		4.6	4.5	*2025*	9
0.29	Veterans Living Below Poverty Level	*percent*	3.8		7.4	7.2	*2019-2023*	2
0.29	Young Children Living Below Poverty Level	*percent*	9.7		20.0	17.6	*2019-2023*	2

0.00	Homeowner Vacancy Rate	*percent*	0.4		0.9	1.0	*2019-2023*	2

SCORE	EDUCATION	UNITS	LAKE COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.53	Student-to-Teacher Ratio	*students/ teacher*	18.0		16.6	15.2	*2023-2024*	13
1.50	High School Graduation	*percent*	93.6	90.7	92.5		*2022-2023*	15
1.18	4th Grade Students Proficient in English/Language Arts	*percent*	69.7		64.1		*2023-2024*	15
1.18	Day Care Center and Preschool Spending-to-Income Ratio	*percent*	6.6		7.4	7.1	*2025*	9
1.06	Child Care Centers	*per 1,000 population under age 5*	8.2		8.0	7.0	*2022*	10
1.00	4th Grade Students Proficient in Math	*percent*	75.1		67.2		*2023-2024*	15
1.00	8th Grade Students Proficient in English/Language Arts	*percent*	56.5		49.4		*2023-2024*	15
1.00	8th Grade Students Proficient in Math	*percent*	53.0		46.3		*2023-2024*	15
1.00	College Tuition Spending-to-Income Ratio	*percent*	11.2		12.6	11.9	*2025*	9
0.88	People 25+ with a Bachelor's Degree or Higher	*percent*	30.5		30.9	35.0	*2019-2023*	2
0.82	Veterans with a High School Diploma or Higher	*percent*	96.1		94.4	95.2	*2019-2023*	2
0.82	Vocational, Technical, and Other School Tuition Spending-to-Income Ratio	*percent*	1.4		1.6	1.5	*2025*	9
0.35	People 25+ with a High School Diploma or Higher	*percent*	93.9		91.6	89.4	*2019-2023*	2

0.29	Home Child Care Spending-to-Income Ratio	*percent*	2.7		3.2	3.3	*2025*	9
0.29	Student Loan Spending-to-Income Ratio	*percent*	4.0		4.6	4.5	*2025*	9

SCORE	ENVIRONMENTAL HEALTH	UNITS	LAKE COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
1.94	Proximity to Highways	*percent*	6.6		7.2		*2020*	14
1.94	Recognized Carcinogens Released into Air	*pounds*	80245.7				*2023*	25
1.76	Adults with Current Asthma	*percent*	10.9			9.9	*2022*	5
1.65	PBT Released	*pounds*	5767.3				*2023*	25
1.65	Weeks of Moderate Drought or Worse	*weeks per year*	5				*2021*	14
1.59	Annual Ozone Air Quality	*grade*	F				*2021-2023*	3
1.56	Annual Particle Pollution	*grade*	C				*2021-2023*	3
1.50	Asthma: Medicare Population	*percent*	7.0		7.0	7.0	*2023*	7
1.47	Daily Dose of UV Irradiance	*Joule per square meter*	3379.0		3384.0		*2020*	14
1.35	Number of Extreme Heat Days	*days*	9				*2023*	14
1.35	Number of Extreme Heat Events	*events*	8				*2023*	14
1.21	Food Environment Index		7.9		7.0		*2025*	10
1.15	Liquor Store Density	*stores/ 100,000 population*	6.5		5.6	10.9	*2022*	23
1.00	Utilities Spending-to-Income Ratio	*percent*	5.7		6.1	5.6	*2025*	9

0.97	Social Vulnerability Index	*Score*	0.1			*2022*	6
0.88	Access to Exercise Opportunities	*percent*	87.8		84.2	*2025*	10
0.82	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	0.6		1.9	*2022*	19
0.76	Overcrowded Households	*percent*	1.2		1.4	3.4	*2019-2023*	2
0.71	Access to Parks	*percent*	70.6		59.6	*2020*	14
0.65	Gasoline and Other Fuels Spending-to-Income Ratio	*percent*	3.0		3.3	3.1	*2025*	9
0.65	Houses Built Prior to 1950	*percent*	14.8		24.9	16.4	*2019-2023*	2
0.56	Air Pollution due to Particulate Matter	*micrograms per cubic meter*	6.2		7.9		*2020*	10
0.44	Broadband Quality Score	*BQS Score*	65.9		53.4	50.0	*2022*	21
0.44	Digital Divide Index	*DDI Score*	15.0		40.1	50.0	*2022*	21
0.44	Severe Housing Problems	*percent*	9.5		12.7		*2017-2021*	10

SCORE	HEALTH CARE ACCESS & QUALITY	UNITS	LAKE COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.35	Primary Care Provider Rate	*providers/ 100,000 population*	41.4		75.3	74.9	*2021*	10
2.21	Preventable Hospital Stays: Medicare Population	*discharges/ 100,000 Medicare enrollees*	3544.0		3269.0	2769.0	*2023*	7
1.35	Health Insurance Spending-to-Income Ratio	*percent*	6.5		6.6	5.9	*2025*	9
1.32	Non-Physician Primary Care Provider Rate	*providers/ 100,000 population*	93.2		148.7		*2024*	10

1.29	Adults with Health Insurance: 18+	*percent*	76.9		74.7	75.2	*2024*	8
1.12	Dentist Rate	*dentists/ 100,000 population*	67.3		65.2	73.5	*2022*	10
1.06	Adults who have had a Routine Checkup	*percent*	79.1			76.1	*2022*	5
0.97	Adults who go to the Doctor Regularly for Checkups	*percent*	67.8		65.2	65.1	*2024*	8
0.97	Adults With Group Health Insurance	*percent*	39.5		37.4	39.8	*2024*	8
0.94	Adults who Visited a Dentist	*percent*	47.5		44.3	45.3	*2024*	8
0.91	Adults with Health Insurance	*percent*	93.8		91.6	89.0	*2023*	1
0.91	Children with Health Insurance	*percent*	97.8		95.1	94.6	*2023*	1
0.82	Persons without Health Insurance	*percent*	4.1		6.1	7.9	*2023*	1
0.79	Adults With Individual Health Insurance	*percent*	22.0		20.5	20.2	*2024*	8
0.74	Persons with Health Insurance	*percent*	93.8	92.4	92.9		*2022*	24
0.71	Adults without Health Insurance	*percent*	4.7			10.8	*2022*	5
0.62	Mental Health Provider Rate	*providers/ 100,000 population*	316.0		349.4		*2024*	10

SCORE	HEART DISEASE & STROKE	UNITS	LAKE COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.21	Hyperlipidemia: Medicare Population	*percent*	70.0		67.0	66.0	*2023*	7
1.94	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	*deaths/ 100,000 population*	43.9	33.4	46.0		*2020-2022*	19
1.85	Stroke: Medicare Population	*percent*	6.0		5.0	6.0	*2023*	7

1.76	Adults who Experienced Coronary Heart Disease	*percent*	8.7			6.8	*2022*	5
1.68	Ischemic Heart Disease: Medicare Population	*percent*	23.0		22.0	21.0	*2023*	7
1.59	High Blood Pressure Prevalence	*percent*	36.2	41.9		32.7	*2021*	5
1.41	Adults who Experienced a Stroke	*percent*	3.9			3.6	*2022*	5
1.41	Adults who Have Taken Medications for High Blood Pressure	*percent*	80.2			78.2	*2021*	5
1.35	Age-Adjusted Death Rate due to Coronary Heart Disease	*deaths/ 100,000 population*	108.6	71.1	101.6		*2020-2022*	19
1.32	Atrial Fibrillation: Medicare Population	*percent*	15.0		15.0	14.0	*2023*	7
1.32	Heart Failure: Medicare Population	*percent*	12.0		12.0	11.0	*2023*	7
1.24	High Cholesterol Prevalence	*percent*	35.1			35.5	*2021*	5
1.15	Hypertension: Medicare Population	*percent*	67.0		67.0	65.0	*2023*	7
0.88	Cholesterol Test History	*percent*	86.9			86.4	*2021*	5
0.71	Age-Adjusted Death Rate due to Heart Attack	*deaths/ 100,000 population 35+ years*	43.9		60.9		*2021*	14

SCORE	IMMUNIZATIONS & INFECTIOUS DISEASES	UNITS	LAKE COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.74	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	10.6		7.8	7.5	*2017-2021*	12
1.50	Syphilis Incidence Rate	*cases/ 100,000 population*	6.9		16.4	15.8	*2023*	16
1.47	Salmonella Infection Incidence Rate	*cases/ 100,000 population*	13.4	11.5	13.8		*2023*	16

1.00	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	10.9		12.3		*2020-2022*	19
0.97	Pneumonia Vaccinations: Medicare Population	*percent*	9.0		9.0	9.0	*2023*	7
0.91	Gonorrhea Incidence Rate	*cases/ 100,000 population*	55.2		168.8	179.5	*2023*	16
0.79	Adults who Agree Vaccine Benefits Outweigh Possible Risks	*Percent*	62.8		59.8	60.4	*2024*	8
0.76	Overcrowded Households	*percent*	1.2		1.4	3.4	*2019-2023*	2
0.62	Flu Vaccinations: Medicare Population	*percent*	51.0		50.0	3.0	*2023*	7
0.56	Tuberculosis Incidence Rate	*cases/ 100,000 population*	0.0	1.4	1.6	2.9	*2023*	16
0.44	Chlamydia Incidence Rate	*cases/ 100,000 population*	204.4		464.2	492.2	*2023*	16

SCORE	MATERNAL, FETAL & INFANT HEALTH	UNITS	LAKE COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
1.65	Preterm Births	*percent*	10.6	9.4	10.8		*2022*	17
1.26	Mothers who Received Early Prenatal Care	*percent*	70.2		68.6	75.3	*2022*	17
1.09	Mothers who Smoked During Pregnancy	*percent*	5.8	4.3	7.9	3.7	*2022*	17
1.03	Babies with Low Birthweight	*percent*	7.6		8.7	8.6	*2022*	17
1.00	Babies with Very Low Birthweight	*percent*	1.0		1.5		*2022*	17
0.88	Infant Mortality Rate	*deaths/ 1,000 live births*	4.0	5.0	6.7	5.4	*2020*	17
0.56	Teen Birth Rate: 15-17	*live births/ 1,000 females aged 15-17*	1.2		6.1	5.6	*2022*	17

SCORE	MENTAL HEALTH & MENTAL DISORDERS	UNITS	LAKE COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.00	Age-Adjusted Death Rate due to Suicide	*deaths/ 100,000 population*	16.8	12.8	14.5		*2020-2022*	19
1.74	Poor Mental Health: Average Number of Days	*days*	6.1		6.1		*2022*	10
1.59	Adults Ever Diagnosed with Depression	*percent*	24.7			20.7	*2022*	5
1.59	Poor Mental Health: 14+ Days	*percent*	17.7			15.8	*2022*	5
1.32	Depression: Medicare Population	*percent*	17.0		18.0	17.0	*2023*	7
1.12	Age-Adjusted Death Rate due to Alzheimer's Disease	*deaths/ 100,000 population*	26.4		33.8		*2020-2022*	19
0.94	Self-Reported General Health Assessment: Good or Better	*percent*	86.5		85.4	86.0	*2024*	8
0.79	Adults who Feel Life is Slipping Out of Control	*Percent*	22.7		24.1	23.9	*2024*	8
0.62	Alzheimer's Disease or Dementia: Medicare Population	*percent*	5.0		6.0	6.0	*2023*	7
0.62	Mental Health Provider Rate	*providers/ 100,000 population*	316.0		349.4		*2024*	10

SCORE	NUTRITION & HEALTHY EATING	UNITS	LAKE COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
1.85	Adults who Frequently Cook Meals at Home	*Percent*	67.7		67.6	67.7	*2024*	8
1.41	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	*Percent*	37.6		38.1	38.2	*2024*	8
1.21	Food Environment Index		7.9		7.0		*2025*	10

0.79	Adults who Drank Soft Drinks: Past 7 Days	*percent*	45.7		48.6	47.5	*2024*	8

SCORE	OLDER ADULTS	UNITS	LAKE COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.82	People 65+ Living Alone	*percent*	30.9		30.2	26.5	*2019-2023*	2
2.47	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	21.1		12.1		*2020-2022*	19
2.38	Osteoporosis: Medicare Population	*percent*	13.0		11.0	12.0	*2023*	7
2.38	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	40.0		39.0	36.0	*2023*	7
2.21	Hyperlipidemia: Medicare Population	*percent*	70.0		67.0	66.0	*2023*	7
2.12	Prostate Cancer Incidence Rate	*cases/ 100,000 males*	114.2		118.1	113.2	*2017-2021*	12
1.94	People 65+ Living Alone (Count)	*people*	15103				*2019-2023*	2
1.94	People 65+ Living Below Poverty Level (Count)	*people*	3438				*2019-2023*	2
1.85	Stroke: Medicare Population	*percent*	6.0		5.0	6.0	*2023*	7
1.68	Ischemic Heart Disease: Medicare Population	*percent*	23.0		22.0	21.0	*2023*	7
1.50	Asthma: Medicare Population	*percent*	7.0		7.0	7.0	*2023*	7
1.50	Cancer: Medicare Population	*percent*	12.0		12.0	12.0	*2023*	7
1.32	Atrial Fibrillation: Medicare Population	*percent*	15.0		15.0	14.0	*2023*	7
1.32	Depression: Medicare Population	*percent*	17.0		18.0	17.0	*2023*	7
1.32	Heart Failure: Medicare Population	*percent*	12.0		12.0	11.0	*2023*	7
1.15	COPD: Medicare Population	*percent*	12.0		13.0	11.0	*2023*	7

1.15	Hypertension: Medicare Population	*percent*	67.0		67.0	65.0	*2023*	7
1.12	Age-Adjusted Death Rate due to Alzheimer's Disease	*deaths/ 100,000 population*	26.4		33.8		*2020-2022*	19
1.06	Adults 65+ with Total Tooth Loss	*percent*	12.2			12.2	*2022*	5
1.00	Adult Day Care Spending-to-Income Ratio	*percent*	10.2		11.1	11.9	*2025*	9
0.97	Diabetes: Medicare Population	*percent*	24.0		25.0	24.0	*2023*	7
0.97	Mammography Screening: Medicare Population	*percent*	51.0		51.0	39.0	*2023*	7
0.88	People 65+ Living Below Poverty Level	*percent*	7.2		9.5	10.4	*2019-2023*	2
0.79	Chronic Kidney Disease: Medicare Population	*percent*	17.0		19.0	18.0	*2023*	7
0.71	Median Household Income: Householders 65+	*dollars*	54575		51608	57108	*2019-2023*	2
0.62	Alzheimer's Disease or Dementia: Medicare Population	*percent*	5.0		6.0	6.0	*2023*	7

SCORE	ORAL HEALTH	UNITS	LAKE COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
1.32	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	12.3		12.8	12.0	*2017-2021*	12
1.12	Dentist Rate	*dentists/ 100,000 population*	67.3		65.2	73.5	*2022*	10
1.06	Adults 65+ with Total Tooth Loss	*percent*	12.2			12.2	*2022*	5
0.94	Adults who Visited a Dentist	*percent*	47.5		44.3	45.3	*2024*	8

SCORE	OTHER CHRONIC CONDITIONS	UNITS	LAKE COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source

2.38	Osteoporosis: Medicare Population	*percent*	13.0		11.0	12.0	*2023*	7
2.38	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	40.0		39.0	36.0	*2023*	7
1.94	Adults with Arthritis	*percent*	33.4			26.6	*2022*	5
1.12	Age-Adjusted Death Rate due to Kidney Disease	*deaths/ 100,000 population*	11.0		15.1		*2020-2022*	19
0.79	Chronic Kidney Disease: Medicare Population	*percent*	17.0		19.0	18.0	*2023*	7

SCORE	PHYSICAL ACTIVITY	UNITS	LAKE COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.71	Workers who Walk to Work	*percent*	1.1		2.0	2.4	*2019-2023*	2
1.47	Adults 20+ Who Are Obese	*percent*	31.5	36.0			*2021*	6
1.00	Adults 20+ who are Sedentary	*percent*	17.6				*2021*	6
0.88	Access to Exercise Opportunities	*percent*	87.8		84.2		*2025*	10
0.71	Access to Parks	*percent*	70.6		59.6		*2020*	14

SCORE	PREVENTION & SAFETY	UNITS	LAKE COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.47	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	21.1		12.1		*2020-2022*	19
1.76	Death Rate due to Injuries	*deaths/ 100,000 population*	102.2		100.7		*2018-2022*	10
1.24	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	38.2	20.7	44.7		*2020-2022*	10
1.15	Age-Adjusted Death Rate due to Unintentional Poisonings	*deaths/ 100,000 population*	40.1		46.5		*2020-2022*	19
0.85	Age-Adjusted Death Rate due to Firearms	*deaths/ 100,000 population*	7.7	10.7	13.5	12.0	*2018-2020*	6

0.71	Death Rate due to Motor Vehicle Collisions	*deaths/ 100,000 population*	6.9		11.1		*2016-2022*	10
0.44	Severe Housing Problems	*percent*	9.5		12.7		*2017-2021*	10

SCORE	RESPIRATORY DISEASES	UNITS	LAKE COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
1.94	Proximity to Highways	*percent*	6.6		7.2		*2020*	14
1.76	Adults with COPD	*Percent of adults*	9.5			6.8	*2022*	5
1.76	Adults with Current Asthma	*percent*	10.9			9.9	*2022*	5
1.53	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	63.8		64.3	53.1	*2017-2021*	12
1.50	Asthma: Medicare Population	*percent*	7.0		7.0	7.0	*2023*	7
1.41	Adults who Smoke	*percent*	16.6	6.1		12.9	*2022*	5
1.15	COPD: Medicare Population	*percent*	12.0		13.0	11.0	*2023*	7
1.00	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	10.9		12.3		*2020-2022*	19
0.88	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	37.4	25.1	39.8	32.4	*2018-2022*	12
0.56	Tuberculosis Incidence Rate	*cases/ 100,000 population*	0.0	1.4	1.6	2.9	*2023*	16
0.53	Age-Adjusted Death Rate due to Chronic Lower Respiratory Diseases	*deaths/ 100,000 population*	32.2		42.8		*2020-2022*	19
0.44	Adults Who Used Electronic Cigarettes: Past 30 Days	*percent*	6.1		6.9	6.8	*2024*	8
0.29	Adults Who Used Smokeless Tobacco: Past 30 Days	*percent*	1.3		1.7	1.6	*2024*	8

SCORE	SEXUALLY TRANSMITTED INFECTIONS	UNITS	LAKE COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
1.50	Syphilis Incidence Rate	*cases/ 100,000 population*	6.9		16.4	15.8	*2023*	16
0.91	Gonorrhea Incidence Rate	*cases/ 100,000 population*	55.2		168.8	179.5	*2023*	16
0.44	Chlamydia Incidence Rate	*cases/ 100,000 population*	204.4		464.2	492.2	*2023*	16

SCORE	TOBACCO USE	UNITS	LAKE COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
1.53	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	63.8		64.3	53.1	*2017-2021*	12
1.41	Adults who Smoke	*percent*	16.6	6.1		12.9	*2022*	5
1.41	Tobacco Use: Medicare Population	*percent*	7.0		7.0	6.0	*2023*	7
1.00	Cigarette Spending-to-Income Ratio	*percent*	2.0		2.1	1.9	*2025*	9
0.44	Adults Who Used Electronic Cigarettes: Past 30 Days	*percent*	6.1		6.9	6.8	*2024*	8
0.29	Adults Who Used Smokeless Tobacco: Past 30 Days	*percent*	1.3		1.7	1.6	*2024*	8

SCORE	WEIGHT STATUS	UNITS	LAKE COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
1.59	Obesity: Medicare Population	*percent*	24.0		25.0	20.0	*2023*	7
1.47	Adults 20+ Who Are Obese	*percent*	31.5	36.0			*2021*	6
1.32	Adults Happy with Weight	*Percent*	42.4		42.1	42.6	*2024*	8

SCORE	WELLNESS & LIFESTYLE	UNITS	LAKE COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source

1.85	Adults who Frequently Cook Meals at Home	*Percent*	67.7		67.6	67.7	*2024*	8
1.76	Insufficient Sleep	*percent*	38.9	26.7		36.0	*2022*	5
1.59	High Blood Pressure Prevalence	*percent*	36.2	41.9		32.7	*2021*	5
1.59	Poor Physical Health: 14+ Days	*percent*	14.1			12.7	*2022*	5
1.41	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	*Percent*	37.6		38.1	38.2	*2024*	8
1.32	Adults Happy with Weight	*Percent*	42.4		42.1	42.6	*2024*	8
1.24	Self-Reported General Health Assessment: Poor or Fair	*percent*	18.1			17.9	*2022*	5
1.21	Poor Physical Health: Average Number of Days	*days*	4.1		4.3		*2022*	10
1.06	Life Expectancy	*years*	77.0		75.2		*2020-2022*	10
0.94	Self-Reported General Health Assessment: Good or Better	*percent*	86.5		85.4	86.0	*2024*	8
0.79	Adults who Agree Vaccine Benefits Outweigh Possible Risks	*Percent*	62.8		59.8	60.4	*2024*	8
0.79	Adults who Feel Life is Slipping Out of Control	*Percent*	22.7		24.1	23.9	*2024*	8

SCORE	WOMEN'S HEALTH	UNITS	LAKE COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.74	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	10.6		7.8	7.5	*2017-2021*	12
2.35	Breast Cancer Incidence Rate	*cases/ 100,000 females*	141.9		132.3	129.8	*2017-2021*	12
0.97	Mammography Screening: Medicare Population	*percent*	51.0		51.0	39.0	*2023*	7

0.88	Cervical Cancer Screening: 21-65	*Percent*	82.8			82.8	*2020*	5
0.88	Mammogram in Past 2 Years: 50-74	*percent*	78.2	80.3		76.5	*2022*	5
0.71	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	18.2	15.3	20.2	19.3	*2018-2022*	12

Lorain County Indicator Scores

Table 24 includes all indicators that were scored as part of the Lorain County secondary data analysis. Refer to Table 23 to identify each indicator's data source.

Table 23: 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	Feeding America
12	National Cancer Institute
13	National Center for Education Statistics
14	National Environmental Public Health Tracking Network
15	Ohio Department of Education
16	Ohio Department of Health, Infectious Diseases
17	Ohio Department of Health, Vital Statistics
18	Ohio Department of Public Safety, Office of Criminal Justice Services
19	Ohio Public Health Information Warehouse
20	Ohio Secretary of State
21	Purdue Center for Regional Development
22	U.S. Bureau of Labor Statistics
23	U.S. Census - County Business Patterns
24	U.S. Census Bureau - Small Area Health Insurance Estimates
25	U.S. Environmental Protection Agency
26	United For ALICE

Table 24: All Lorain County Secondary Data Indicators

SCORE	ALCOHOL & DRUG USE	UNITS	LORAIN COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.21	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate	*Deaths per 100,000 population*	42.1		40.4	23.5	*2018-2020*	6
2.15	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	37.3		32.1		*2018-2022*	10
1.94	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	45.5	20.7	44.7		*2020-2022*	10
1.76	Adults who Binge Drink	*percent*	18.1			16.6	*2022*	5
1.74	Adults who Drink Excessively	*percent*	20.9		21.2		*2022*	10
1.32	Mothers who Smoked During Pregnancy	*percent*	8.1	4.3	7.9	3.7	*2022*	17
1.18	Liquor Store Density	*stores/ 100,000 population*	7		5.6	10.9	*2022*	23

SCORE	CANCER	UNITS	LORAIN COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.53	Breast Cancer Incidence Rate	*cases/ 100,000 females*	142.9		132.3	129.8	*2017-2021*	12
2.35	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	22	15.3	20.2	19.3	*2018-2022*	12
2.35	Prostate Cancer Incidence Rate	*cases/ 100,000 males*	124.7		118.1	113.2	*2017-2021*	12
2.00	All Cancer Incidence Rate	*cases/ 100,000 population*	487.6		470	444.4	*2017-2021*	12
1.82	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	13.3		12.8	12	*2017-2021*	12
1.59	Adults with Cancer (Non-Skin) or Melanoma	*percent*	9.2			8.2	*2022*	5
1.50	Cancer: Medicare Population	*percent*	12		12	12	*2023*	7
1.41	Colon Cancer Screening: USPSTF Recommendation	*percent*	65.4			66.3	*2022*	5

1.41	Mammogram in Past 2 Years: 50-74	*percent*	74.4	80.3		76.5	*2022*	5
1.24	Cervical Cancer Screening: 21-65	*Percent*	82.4			82.8	*2020*	5
1.06	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	61.6		64.3	53.1	*2017-2021*	12
1.00	Colorectal Cancer Incidence Rate	*cases/ 100,000 population*	37.3		38.9	36.4	*2017-2021*	12
0.91	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	6.8		7.8	7.5	*2017-2021*	12
0.71	Age-Adjusted Death Rate due to Cancer	*deaths/ 100,000 population*	158.4	122.7	161.1	146	*2018-2022*	12
0.71	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	35.8	25.1	39.8	32.4	*2018-2022*	12
0.62	Mammography Screening: Medicare Population	*percent*	53		51	39	*2023*	7
0.29	Age-Adjusted Death Rate due to Prostate Cancer	*deaths/ 100,000 males*	16.3	16.9	19.3	19	*2018-2022*	12
0.00	Age-Adjusted Death Rate due to Colorectal Cancer	*deaths/ 100,000 population*	11.4	8.9	13.9	12.9	*2018-2022*	12

SCORE	**CHILDREN'S HEALTH**	**UNITS**	**LORAIN COUNTY**	**HP2030**	**OH**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
1.47	Child Food Insecurity Rate	*percent*	19.3		20.1	18.4	*2023*	11
1.47	Substantiated Child Abuse Rate	*cases/ 1,000 children*	6.6	8.7	6.9		*2021*	4
1.41	Child Care Centers	*per 1,000 population under age 5*	7.8		8	7	*2022*	10
1.06	Child Mortality Rate: Under 20	*deaths/ 100,000 population under 20*	51		59.2		*2019-2022*	10
1.00	Blood Lead Levels in Children (>=10 micrograms per deciliter)	*percent*	0.1		0.5		*2022*	19
1.00	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	0.9		1.9		*2022*	19

1.00	Home Child Care Spending-to-Income Ratio	*percent*	3.1		3.2	3.3	*2025*	9
0.91	Children with Health Insurance	*percent*	98.1		95.1	94.6	*2023*	1

SCORE	COMMUNITY	UNITS	LORAIN COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.71	Children in Single-Parent Households	*percent*	29.2		26.1	24.8	*2019-2023*	2
2.65	Median Monthly Owner Costs for Households without a Mortgage	*dollars*	615		570	612	*2019-2023*	2
2.35	Workers who Walk to Work	*percent*	1.6		2	2.4	*2019-2023*	2
2.15	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	37.3		32.1		*2018-2022*	10
2.12	Mortgaged Owners Median Monthly Household Costs	*dollars*	1495		1472	1902	*2019-2023*	2
2.09	Social Associations	*membership associations/ 10,000 population*	9.5		10.8		*2022*	10
2.09	Solo Drivers with a Long Commute	*percent*	37.1		30.5		*2019-2023*	10
2.06	Young Children Living Below Poverty Level	*percent*	23.3		20	17.6	*2019-2023*	2
2.00	Adults with Internet Access	*percent*	80.8		80.9	81.3	*2024*	8
2.00	Linguistic Isolation	*percent*	1.7		1.5	4.2	*2019-2023*	2
2.00	People 65+ Living Alone	*percent*	29.9		30.2	26.5	*2019-2023*	2
2.00	Workers Commuting by Public Transportation	*percent*	0.4	5.3	1.1	3.5	*2019-2023*	2
1.94	People 65+ Living Alone (Count)	*people*	18231				*2019-2023*	2
1.88	Children Living Below Poverty Level	*percent*	18.8		18	16.3	*2019-2023*	2
1.82	Mean Travel Time to Work	*minutes*	25.4		23.6	26.6	*2019-2023*	2
1.76	Median Household Gross Rent	*dollars*	916		988	1348	*2019-2023*	2

1.74	Grandparents Who Are Responsible for Their Grandchildren	*percent*	40.8		41.3	32	*2019-2023*	2
1.71	Day Care Center and Preschool Spending-to-Income Ratio	*percent*	7.2		7.4	7.1	*2025*	9
1.68	Age-Adjusted Death Rate due to Homicide	*deaths/ 100,000 population*	6.9	5.5	9		*2020-2022*	19
1.50	Adults With Group Health Insurance	*percent*	37.3		37.4	39.8	*2024*	8
1.50	Social Vulnerability Index	*Score*	0.4				*2022*	6
1.47	Substantiated Child Abuse Rate	*cases/ 1,000 children*	6.6	8.7	6.9		*2021*	4
1.44	Persons with Health Insurance	*percent*	92.7	92.4	92.9		*2022*	24
1.41	Households with an Internet Subscription	*percent*	86.9		89	89.9	*2019-2023*	2
1.41	Workers who Drive Alone to Work	*percent*	78.6		76.6	70.2	*2019-2023*	2
1.38	Residential Segregation - Black/White	*Score*	58.9		69.6		*2025*	10
1.35	Adult Day Care Spending-to-Income Ratio	*percent*	11		11.1	11.9	*2025*	9
1.35	Female Population 16+ in Civilian Labor Force	*percent*	57.5		59.2	58.7	*2019-2023*	2
1.35	Violent Crime Rate	*crimes/ 100,000 population*	233		331		*2024*	18
1.32	Adults Who Vote in Presidential Elections: Always or Sometimes	*percent*	85.7		84.9	85.1	*2024*	8
1.24	People 25+ with a Bachelor's Degree or Higher	*percent*	27.9		30.9	35	*2019-2023*	2
1.24	Persons with an Internet Subscription	*percent*	89.4		91.3	92	*2019-2023*	2
1.24	Population 16+ in Civilian Labor Force	*percent*	58		60.1	59.8	*2019-2023*	2
1.18	Gasoline and Other Fuels Spending-to-Income Ratio	*percent*	3.3		3.3	3.1	*2025*	9
1.18	Households with a Computer	*percent*	85.8		85.2	86	*2024*	8

1.18	People Living Below Poverty Level	*percent*	12.8	8	13.2	12.4	*2019-2023*	2
1.06	Households with a Smartphone	*percent*	87.1		87.5	88.2	*2024*	8
1.06	Voter Turnout: Presidential Election	*percent*	72.7	58.4	71.7		*2024*	20
1.06	Youth not in School or Working	*percent*	1.7		1.7	1.7	*2019-2023*	2
0.97	Digital Distress		1				*2022*	21
0.97	Total Employment Change	*percent*	5.5		2.9	5.8	*2021-2022*	23
0.91	Age-Adjusted Death Rate due to Firearms	*deaths/ 100,000 population*	11.1	10.7	13.5	12	*2018-2020*	6
0.88	Median Household Income	*dollars*	70693		69680	78538	*2019-2023*	2
0.88	People 25+ with a High School Diploma or Higher	*percent*	91.5		91.6	89.4	*2019-2023*	2
0.82	Age-Adjusted Death Rate due to Motor Vehicle Collisions	*deaths/ 100,000 population*	2.1		2.7	2.6	*2016-2020*	6
0.79	Adults With Individual Health Insurance	*percent*	20.9		20.5	20.2	*2024*	8
0.71	Death Rate due to Motor Vehicle Collisions	*deaths/ 100,000 population*	9.3		11.1		*2016-2022*	10
0.71	Households with One or More Types of Computing Devices	*percent*	94.4		93.6	94.8	*2019-2023*	2
0.62	Digital Divide Index	*DDI Score*	16.7		40.1	50	*2022*	21
0.53	Per Capita Income	*dollars*	39638		39455	43289	*2019-2023*	2
0.44	Broadband Quality Score	*BQS Score*	66.7		53.4	50	*2022*	21

SCORE	**DIABETES**	**UNITS**	**LORAIN COUNTY**	**HP2030**	**OH**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
1.41	Age-Adjusted Death Rate due to Diabetes	*deaths/ 100,000 population*	22.8		26.4	22.6	*2018-2020*	6
1.24	Adults 20+ with Diabetes	*percent*	9.6				*2021*	6
1.15	Diabetes: Medicare Population	*percent*	25		25	24	*2023*	7

SCORE	**ECONOMY**	**UNITS**	**LORAIN COUNTY**	**HP2030**	**OH**	**U.S.**	**MEASUREMENT PERIOD**	**Source**

2.65	Median Monthly Owner Costs for Households without a Mortgage	*dollars*	615	570	612	*2019-2023*	2
2.41	Households with Cash Public Assistance Income	*percent*	3.1	2.5	2.7	*2019-2023*	2
2.24	Homeowner Spending-to-Income Ratio	*percent*	15	14.3	13.5	*2025*	9
2.12	Households that are Above the Asset Limited, Income Constrained, Employed (ALICE) Threshold	*percent*	59.9	61		*2022*	26
2.12	Households that are Asset Limited, Income Constrained, Employed (ALICE)	*percent*	27.1	25		*2022*	26
2.12	Mortgaged Owners Median Monthly Household Costs	*dollars*	1495	1472	1902	*2019-2023*	2
2.12	People 65+ Living Below Poverty Level	*percent*	10.3	9.5	10.4	*2019-2023*	2
2.09	Severe Housing Problems	*percent*	12.9	12.7		*2017-2021*	10
2.06	Young Children Living Below Poverty Level	*percent*	23.3	20	17.6	*2019-2023*	2
1.94	People 65+ Living Below Poverty Level (Count)	*people*	6116			*2019-2023*	2
1.88	Children Living Below Poverty Level	*percent*	18.8	18	16.3	*2019-2023*	2
1.88	Unemployed Veterans	*percent*	3.5	2.8	3.2	*2019-2023*	2
1.85	Income Inequality		0.5	0.5	0.5	*2019-2023*	2
1.82	Food Insecurity Rate	*percent*	15.4	15.3	14.5	*2023*	11
1.76	Median Household Gross Rent	*dollars*	916	988	1348	*2019-2023*	2
1.71	Day Care Center and Preschool Spending-to-Income Ratio	*percent*	7.2	7.4	7.1	*2025*	9
1.71	Health Insurance Spending-to-Income Ratio	*percent*	6.8	6.6	5.9	*2025*	9
1.68	Households Spending 50% or More of Household Income on Housing	*percent*	12.1	11.5	14.3	*2019-2023*	2

1.53	Cigarette Spending-to-Income Ratio	*percent*	2.1		2.1	1.9	*2025*	9
1.53	College Tuition Spending-to-Income Ratio	*percent*	12.3		12.6	11.9	*2025*	9
1.53	Renters Spending 30% or More of Household Income on Rent	*percent*	46.3	25.5	45.1	50.4	*2019-2023*	2
1.53	Utilities Spending-to-Income Ratio	*percent*	6.2		6.1	5.6	*2025*	9
1.47	Child Food Insecurity Rate	*percent*	19.3		20.1	18.4	*2023*	11
1.38	Residential Segregation - Black/White	*Score*	58.9		69.6		*2025*	10
1.35	Adult Day Care Spending-to-Income Ratio	*percent*	11		11.1	11.9	*2025*	9
1.35	Families Living Below Poverty Level	*percent*	9.1		9.2	8.7	*2019-2023*	2
1.35	Female Population 16+ in Civilian Labor Force	*percent*	57.5		59.2	58.7	*2019-2023*	2
1.35	Home Renter Spending-to-Income Ratio	*percent*	15.6		16.3	17	*2025*	9
1.35	Households with a 401k Plan	*percent*	38.2		38.4	40.8	*2024*	8
1.35	Vocational, Technical, and Other School Tuition Spending-to-Income Ratio	*percent*	1.6		1.6	1.5	*2025*	9
1.29	Unemployed Workers in Civilian Labor Force	*percent*	4.5		5.2	4.2	*45717*	22
1.24	Population 16+ in Civilian Labor Force	*percent*	58		60.1	59.8	*2019-2023*	2
1.18	Gasoline and Other Fuels Spending-to-Income Ratio	*percent*	3.3		3.3	3.1	*2025*	9
1.18	Households Living Below Poverty Level	*percent*	13		14		*2022*	26
1.18	Households with a Savings Account	*percent*	71.5		70.9	72	*2024*	8
1.18	People Living Below Poverty Level	*percent*	12.8	8	13.2	12.4	*2019-2023*	2
1.18	Student Loan Spending-to-Income Ratio	*percent*	4.4		4.6	4.5	*2025*	9

1.09	Gender Pay Gap	*cents on the dollar*	0.8		0.7	0.8	*2023*	1
1.06	Children Living Below 200% of Poverty Level	*percent*	32.6		38.3	36.1	*2023*	1
1.06	Size of Labor Force	*persons*	156358				*45717*	22
1.06	Youth not in School or Working	*percent*	1.7		1.7	1.7	*2019-2023*	2
1.03	Mortgaged Owners Spending 30% or More of Household Income on Housing	*percent*	20.5	25.5	21.2	28.5	*2023*	1
1.00	Home Child Care Spending-to-Income Ratio	*percent*	3.1		3.2	3.3	*2025*	9
1.00	Veterans Living Below Poverty Level	*percent*	7.1		7.4	7.2	*2019-2023*	2
0.97	Total Employment Change	*percent*	5.5		2.9	5.8	*2021-2022*	23
0.94	Students Eligible for the Free Lunch Program	*percent*	24.4		23.6	43.6	*2023-2024*	13
0.88	Households with Student Loan Debt	*percent*	8.3		9.1	9.8	*2024*	8
0.88	Median Household Income	*dollars*	70693		69680	78538	*2019-2023*	2
0.88	Median Household Income: Householders 65+	*dollars*	52950		51608	57108	*2019-2023*	2
0.79	Adults who Feel Overwhelmed by Financial Burdens	*percent*	32.7		34	33.6	*2024*	8
0.76	Overcrowded Households	*percent*	1.2		1.4	3.4	*2019-2023*	2
0.74	Families Living Below 200% of Poverty Level	*Percent*	19.1		22.8	22.3	*2023*	1
0.74	People 65+ Living Below 200% of Poverty Level	*percent*	23.9		28.4	28.1	*2023*	1
0.74	People Living Below 200% of Poverty Level	*percent*	24.8		29.6	28.2	*2023*	1
0.53	Adults with Disability Living in Poverty	*percent*	24.5		28.2	24.6	*2019-2023*	2
0.53	Per Capita Income	*dollars*	39638		39455	43289	*2019-2023*	2
0.35	Homeowner Vacancy Rate	*percent*	0.8		0.9	1	*2019-2023*	2
0.18	Households that Used Check Cashing, Cash Advance, or Title Loan Shops	*percent*	1.8		2	2	*2024*	8

SCORE	EDUCATION	UNITS	LORAIN COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.35	Student-to-Teacher Ratio	*students/ teacher*	17.1		16.6	15.2	*2023-2024*	13
1.85	High School Graduation	*percent*	90.8	90.7	92.5		*2022-2023*	15
1.71	Day Care Center and Preschool Spending-to-Income Ratio	*percent*	7.2		7.4	7.1	*2025*	9
1.53	4th Grade Students Proficient in English/Language Arts	*percent*	63		64.1		*2023-2024*	15
1.53	College Tuition Spending-to-Income Ratio	*percent*	12.3		12.6	11.9	*2025*	9
1.41	4th Grade Students Proficient in Math	*percent*	67.1		67.2		*2023-2024*	15
1.41	Child Care Centers	*per 1,000 population under age 5*	7.8		8	7	*2022*	10
1.35	8th Grade Students Proficient in Math	*percent*	46.9		46.3		*2023-2024*	15
1.35	Vocational, Technical, and Other School Tuition Spending-to-Income Ratio	*percent*	1.6		1.6	1.5	*2025*	9
1.32	8th Grade Students Proficient in English/Language Arts	*percent*	52		49.4		*2023-2024*	15
1.24	People 25+ with a Bachelor's Degree or Higher	*percent*	27.9		30.9	35	*2019-2023*	2
1.24	Veterans with a High School Diploma or Higher	*percent*	94.2		94.4	95.2	*2019-2023*	2
1.18	Student Loan Spending-to-Income Ratio	*percent*	4.4		4.6	4.5	*2025*	9
1.00	Home Child Care Spending-to-Income Ratio	*percent*	3.1		3.2	3.3	*2025*	9
0.88	People 25+ with a High School Diploma or Higher	*percent*	91.5		91.6	89.4	*2019-2023*	2

SCORE	ENVIRONMENTAL HEALTH	UNITS	LORAIN COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source

2.29	Daily Dose of UV Irradiance	*Joule per square meter*	3701	3384		*2020*	14
2.12	Proximity to Highways	*percent*	7.7	7.2		*2020*	14
2.09	Severe Housing Problems	*percent*	12.9	12.7		*2017-2021*	10
1.76	Adults with Current Asthma	*percent*	11		9.9	*2022*	5
1.65	Weeks of Moderate Drought or Worse	*weeks per year*	2			*2021*	14
1.56	Annual Particle Pollution	*Grade*	B			*2019-2021*	3
1.56	Food Environment Index		7.6	7		*2025*	10
1.53	Utilities Spending-to-Income Ratio	*percent*	6.2	6.1	5.6	*2025*	9
1.50	Asthma: Medicare Population	*percent*	7	7	7	*2023*	7
1.50	Social Vulnerability Index	*Score*	0.4			*2022*	6
1.35	Number of Extreme Heat Days	*days*	12			*2023*	14
1.35	Number of Extreme Heat Events	*events*	7			*2023*	14
1.35	PBT Released	*pounds*	4376.6			*2023*	25
1.35	Recognized Carcinogens Released into Air	*pounds*	2437.3			*2023*	25
1.26	Annual Ozone Air Quality	*Grade*	B			*2020-2022*	3
1.18	Gasoline and Other Fuels Spending-to-Income Ratio	*percent*	3.3	3.3	3.1	*2025*	9
1.18	Liquor Store Density	*stores/ 100,000 population*	7	5.6	10.9	*2022*	23
1.06	Number of Extreme Precipitation Days	*days*	3			*2023*	14
1.00	Blood Lead Levels in Children (>=10 micrograms per deciliter)	*percent*	0.1	0.5		*2022*	19
1.00	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	0.9	1.9		*2022*	19
0.88	Access to Parks	*percent*	61.7	59.6		*2020*	14
0.88	Houses Built Prior to 1950	*percent*	19.5	24.9	16.4	*2019-2023*	2
0.76	Overcrowded Households	*percent*	1.2	1.4	3.4	*2019-2023*	2

0.74	Air Pollution due to Particulate Matter	*micrograms per cubic meter*	6.8		7.9		*2020*	10
0.71	Access to Exercise Opportunities	*percent*	95		84.2		*2025*	10
0.62	Digital Divide Index	*DDI Score*	16.7		40.1	50	*2022*	21
0.44	Broadband Quality Score	*BQS Score*	66.7		53.4	50	*2022*	21

SCORE	HEALTH CARE ACCESS & QUALITY	UNITS	LORAIN COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.29	Primary Care Provider Rate	*providers/ 100,000 population*	51.6		75.3	74.9	*2021*	10
2.03	Preventable Hospital Stays: Medicare Population	*discharges/ 100,000 Medicare enrollees*	3494		3269	2769	*2023*	7
1.85	Dentist Rate	*dentists/ 100,000 population*	49		65.2	73.5	*2022*	10
1.71	Health Insurance Spending-to-Income Ratio	*percent*	6.8		6.6	5.9	*2025*	9
1.50	Adults With Group Health Insurance	*percent*	37.3		37.4	39.8	*2024*	8
1.47	Adults with Health Insurance: 18+	*percent*	75.3		74.7	75.2	*2024*	8
1.44	Persons with Health Insurance	*percent*	92.7	92.4	92.9		*2022*	24
1.32	Adults who go to the Doctor Regularly for Checkups	*percent*	66.4		65.2	65.1	*2024*	8
1.32	Non-Physician Primary Care Provider Rate	*providers/ 100,000 population*	92.2		148.7		*2024*	10
1.29	Adults who Visited a Dentist	*percent*	45.6		44.3	45.3	*2024*	8
1.24	Adults without Health Insurance	*percent*	6.3			10.8	*2022*	5
1.15	Mental Health Provider Rate	*providers/ 100,000 population*	224		349.4		*2024*	10

1.09	Adults with Health Insurance	*percent*	93.2		91.6	89	*2023*	1
0.91	Children with Health Insurance	*percent*	98.1		95.1	94.6	*2023*	1
0.88	Adults who have had a Routine Checkup	*percent*	79.6			76.1	*2022*	5
0.79	Adults With Individual Health Insurance	*percent*	20.9		20.5	20.2	*2024*	8
0.74	Persons without Health Insurance	*percent*	5.3		6.4	8.6	*2019-2023*	2

SCORE	HEART DISEASE & STROKE	UNITS	LORAIN COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.56	Ischemic Heart Disease: Medicare Population	*percent*	25		22	21	*2023*	7
2.56	Stroke: Medicare Population	*percent*	7		5	6	*2023*	7
2.21	Atrial Fibrillation: Medicare Population	*percent*	16		15	14	*2023*	7
2.21	Hyperlipidemia: Medicare Population	*percent*	71		67	66	*2023*	7
1.94	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	*deaths/ 100,000 population*	40.5	33.4	43.4	37.6	*2018-2020*	6
1.94	High Blood Pressure Prevalence	*percent*	38.2	41.9		32.7	*2021*	5
1.85	Hypertension: Medicare Population	*percent*	70		67	65	*2023*	7
1.76	Adults who Experienced Coronary Heart Disease	*percent*	8.5			6.8	*2022*	5
1.41	Adults who Experienced a Stroke	*percent*	3.9			3.6	*2022*	5
1.41	High Cholesterol Prevalence	*percent*	35.6			35.5	*2021*	5
1.32	Heart Failure: Medicare Population	*percent*	12		12	11	*2023*	7
1.24	Adults who Have Taken Medications for High Blood Pressure	*percent*	81.3			78.2	*2021*	5
1.24	Cholesterol Test History	*percent*	85.3			86.4	*2021*	5

0.71	Age-Adjusted Death Rate due to Heart Attack	*deaths/ 100,000 population 35+ years*	42.5		60.9		*2021*	14
0.35	Age-Adjusted Death Rate due to Coronary Heart Disease	*deaths/ 100,000 population*	81.9	71.1	101.9	90.2	*2018-2020*	6

SCORE	IMMUNIZATIONS & INFECTIOUS DISEASES	UNITS	LORAIN COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
1.29	Salmonella Infection Incidence Rate	*cases/ 100,000 population*	12.3	11.5	13.8		*2023*	16
1.21	Tuberculosis Incidence Rate	*cases/ 100,000 population*	0.9	1.4	1.6	2.9	*2023*	16
1.09	Chlamydia Incidence Rate	*cases/ 100,000 population*	374		464.2	492.2	*2023*	16
1.09	Gonorrhea Incidence Rate	*cases/ 100,000 population*	99.9		168.8	179.5	*2023*	16
1.03	Syphilis Incidence Rate	*cases/ 100,000 population*	6		16.4	15.8	*2023*	16
0.91	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	6.8		7.8	7.5	*2017-2021*	12
0.82	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	12.3		13.9	13.4	*2018-2020*	6
0.79	Adults who Agree Vaccine Benefits Outweigh Possible Risks	*Percent*	60.8		59.8	60.4	*2024*	8
0.76	Overcrowded Households	*percent*	1.2		1.4	3.4	*2019-2023*	2
0.62	Flu Vaccinations: Medicare Population	*percent*	53		50	3	*2023*	7
0.44	Pneumonia Vaccinations: Medicare Population	*percent*	10		9	9	*2023*	7

SCORE	MATERNAL, FETAL & INFANT HEALTH	UNITS	LORAIN COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.74	Babies with Low Birthweight	*percent*	9.7		8.7	8.6	*2022*	17
2.18	Babies with Very Low Birthweight	*percent*	1.8		1.5		*2022*	17
2.18	Preterm Births	*percent*	12.4	9.4	10.8		*2022*	17

1.62	Infant Mortality Rate	*deaths/ 1,000 live births*	6.3	5	6.7	5.4	*2020*	17
1.32	Mothers who Smoked During Pregnancy	*percent*	8.1	4.3	7.9	3.7	*2022*	17
1.09	Teen Birth Rate: 15-17	*live births/ 1,000 females aged 15-17*	5.5		6.1	5.6	*2022*	17
0.97	Mothers who Received Early Prenatal Care	*percent*	70.3		68.6	75.3	*2022*	17

SCORE	MENTAL HEALTH & MENTAL DISORDERS	UNITS	LORAIN COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.29	Adults Ever Diagnosed with Depression	*percent*	27.6			20.7	*2022*	5
2.12	Poor Mental Health: 14+ Days	*percent*	19.6			15.8	*2022*	5
2.09	Poor Mental Health: Average Number of Days	*days*	6.3		6.1		*2022*	10
1.68	Age-Adjusted Death Rate due to Suicide	*deaths/ 100,000 population*	15.4	12.8	14.7	13.9	*2018-2020*	6
1.68	Depression: Medicare Population	*percent*	18		18	17	*2023*	7
1.47	Self-Reported General Health Assessment: Good or Better	*percent*	85.8		85.4	86	*2024*	8
1.32	Alzheimer's Disease or Dementia: Medicare Population	*percent*	6		6	6	*2023*	7
1.15	Mental Health Provider Rate	*providers/ 100,000 population*	224		349.4		*2024*	10
0.97	Adults who Feel Life is Slipping Out of Control	*Percent*	23.1		24.1	23.9	*2024*	8
0.18	Age-Adjusted Death Rate due to Alzheimer's Disease	*deaths/ 100,000 population*	27.1		35.5	31	*2018-2020*	6

SCORE	NUTRITION & HEALTHY EATING	UNITS	LORAIN COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.03	Adults who Frequently Cook Meals at Home	*Percent*	67.3		67.6	67.7	*2024*	8

1.56	Food Environment Index		7.6		7	*2025*	10
1.41	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	*Percent*	37.6		38.1	38.2	*2024*	8
0.97	Adults who Drank Soft Drinks: Past 7 Days	*percent*	47.7		48.6	47.5	*2024*	8

SCORE	OLDER ADULTS	UNITS	LORAIN COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.82	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	14.6		10.8	9.8	*2018-2020*	6
2.56	Chronic Kidney Disease: Medicare Population	*percent*	23		19	18	*2023*	7
2.56	Ischemic Heart Disease: Medicare Population	*percent*	25		22	21	*2023*	7
2.56	Stroke: Medicare Population	*percent*	7		5	6	*2023*	7
2.38	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	42		39	36	*2023*	7
2.35	Prostate Cancer Incidence Rate	*cases/ 100,000 males*	124.7		118.1	113.2	*2017-2021*	12
2.21	Atrial Fibrillation: Medicare Population	*percent*	16		15	14	*2023*	7
2.21	COPD: Medicare Population	*percent*	15		13	11	*2023*	7
2.21	Hyperlipidemia: Medicare Population	*percent*	71		67	66	*2023*	7
2.12	People 65+ Living Below Poverty Level	*percent*	10.3		9.5	10.4	*2019-2023*	2
2.00	People 65+ Living Alone	*percent*	29.9		30.2	26.5	*2019-2023*	2
1.94	People 65+ Living Alone (Count)	*people*	18231				*2019-2023*	2
1.94	People 65+ Living Below Poverty Level (Count)	*people*	6116				*2019-2023*	2
1.85	Hypertension: Medicare Population	*percent*	70		67	65	*2023*	7
1.85	Osteoporosis: Medicare Population	*percent*	12		11	12	*2023*	7

1.68	Depression: Medicare Population	*percent*	18		18	17	*2023*	7
1.50	Asthma: Medicare Population	*percent*	7		7	7	*2023*	7
1.50	Cancer: Medicare Population	*percent*	12		12	12	*2023*	7
1.35	Adult Day Care Spending-to-Income Ratio	*percent*	11		11.1	11.9	*2025*	9
1.32	Alzheimer's Disease or Dementia: Medicare Population	*percent*	6		6	6	*2023*	7
1.32	Heart Failure: Medicare Population	*percent*	12		12	11	*2023*	7
1.15	Diabetes: Medicare Population	*percent*	25		25	24	*2023*	7
0.88	Median Household Income: Householders 65+	*dollars*	52950		51608	57108	*2019-2023*	2
0.71	Adults 65+ with Total Tooth Loss	*percent*	8.5			12.2	*2022*	5
0.62	Mammography Screening: Medicare Population	*percent*	53		51	39	*2023*	7
0.18	Age-Adjusted Death Rate due to Alzheimer's Disease	*deaths/ 100,000 population*	27.1		35.5	31	*2018-2020*	6

SCORE	ORAL HEALTH	UNITS	LORAIN COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
1.85	Dentist Rate	*dentists/ 100,000 population*	49		65.2	73.5	*2022*	10
1.82	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	13.3		12.8	12	*2017-2021*	12
1.29	Adults who Visited a Dentist	*percent*	45.6		44.3	45.3	*2024*	8
0.71	Adults 65+ with Total Tooth Loss	*percent*	8.5			12.2	*2022*	5

SCORE	OTHER CHRONIC CONDITIONS	UNITS	LORAIN COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.56	Chronic Kidney Disease: Medicare Population	*percent*	23		19	18	*2023*	7

2.38	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	42		39	36	*2023*	7
1.85	Osteoporosis: Medicare Population	*percent*	12		11	12	*2023*	7
1.82	Age-Adjusted Death Rate due to Kidney Disease	*deaths/ 100,000 population*	14.2		14.2	12.8	*2018-2020*	6
1.76	Adults with Arthritis	*percent*	31.7			26.6	*2022*	5

SCORE	PHYSICAL ACTIVITY	UNITS	LORAIN COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.35	Workers who Walk to Work	*percent*	1.6		2	2.4	*2019-2023*	2
1.53	Adults 20+ Who Are Obese	*percent*	33.9	36			*2021*	6
1.18	Adults 20+ who are Sedentary	*percent*	20				*2021*	6
0.88	Access to Parks	*percent*	61.7		59.6		*2020*	14
0.71	Access to Exercise Opportunities	*percent*	95		84.2		*2025*	10

SCORE	PREVENTION & SAFETY	UNITS	LORAIN COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.82	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	14.6		10.8	9.8	*2018-2020*	6
2.35	Age-Adjusted Death Rate due to Unintentional Poisonings	*deaths/ 100,000 population*	42.1		40.5	23.5	*2018-2020*	6
2.09	Severe Housing Problems	*percent*	12.9		12.7		*2017-2021*	10
1.94	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	45.5	20.7	44.7		*2020-2022*	10
1.76	Death Rate due to Injuries	*deaths/ 100,000 population*	101.7		100.7		*2018-2022*	10
1.71	Age-Adjusted Death Rate due to Unintentional Injuries	*deaths/ 100,000 population*	69.9	43.2	69.9	51.6	*2018-2020*	6
0.91	Age-Adjusted Death Rate due to Firearms	*deaths/ 100,000 population*	11.1	10.7	13.5	12	*2018-2020*	6
0.82	Age-Adjusted Death Rate due to Motor Vehicle Collisions	*deaths/ 100,000 population*	2.1		2.7	2.6	*2016-2020*	6

0.71	Death Rate due to Motor Vehicle Collisions	*deaths/ 100,000 population*	9.3		11.1		*2016-2022*	10

SCORE	RESPIRATORY DISEASES	UNITS	LORAIN COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.21	COPD: Medicare Population	*percent*	15		13	11	*2023*	7
2.12	Proximity to Highways	*percent*	7.7		7.2		*2020*	14
2.06	Age-Adjusted Death Rate due to Chronic Lower Respiratory Diseases	*deaths/ 100,000 population*	53.7		46.5	38.1	*2018-2020*	6
1.76	Adults who Smoke	*percent*	18.7	6.1		12.9	*2022*	5
1.76	Adults with COPD	*Percent of adults*	9.7			6.8	*2022*	5
1.76	Adults with Current Asthma	*percent*	11			9.9	*2022*	5
1.50	Asthma: Medicare Population	*percent*	7		7	7	*2023*	7
1.21	Tuberculosis Incidence Rate	*cases/ 100,000 population*	0.9	1.4	1.6	2.9	*2023*	16
1.06	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	61.6		64.3	53.1	*2017-2021*	12
0.82	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	12.3		13.9	13.4	*2018-2020*	6
0.79	Adults Who Used Electronic Cigarettes: Past 30 Days	*percent*	6.4		6.9	6.8	*2024*	8
0.71	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	35.8	25.1	39.8	32.4	*2018-2022*	12
0.47	Adults Who Used Smokeless Tobacco: Past 30 Days	*percent*	1.4		1.7	1.6	*2024*	8

SCORE	SEXUALLY TRANSMITTED INFECTIONS	UNITS	LORAIN COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
1.09	Chlamydia Incidence Rate	*cases/ 100,000 population*	374		464.2	492.2	*2023*	16
1.09	Gonorrhea Incidence Rate	*cases/ 100,000 population*	99.9		168.8	179.5	*2023*	16
1.03	Syphilis Incidence Rate	*cases/ 100,000 population*	6		16.4	15.8	*2023*	16

SCORE	TOBACCO USE	UNITS	LORAIN COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
1.76	Adults who Smoke	*percent*	18.7	6.1		12.9	*2022*	5
1.53	Cigarette Spending-to-Income Ratio	*percent*	2.1		2.1	1.9	*2025*	9
1.41	Tobacco Use: Medicare Population	*percent*	7		7	6	*2023*	7
1.06	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	61.6		64.3	53.1	*2017-2021*	12
0.79	Adults Who Used Electronic Cigarettes: Past 30 Days	*percent*	6.4		6.9	6.8	*2024*	8
0.47	Adults Who Used Smokeless Tobacco: Past 30 Days	*percent*	1.4		1.7	1.6	*2024*	8

SCORE	WEIGHT STATUS	UNITS	LORAIN COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.29	Obesity: Medicare Population	*percent*	31		25	20	*2023*	7
1.85	Adults Happy with Weight	*Percent*	41.9		42.1	42.6	*2024*	8
1.53	Adults 20+ Who Are Obese	*percent*	33.9	36			*2021*	6

SCORE	WELLNESS & LIFESTYLE	UNITS	LORAIN COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.03	Adults who Frequently Cook Meals at Home	*Percent*	67.3		67.6	67.7	*2024*	8
1.94	High Blood Pressure Prevalence	*percent*	38.2	41.9		32.7	*2021*	5
1.85	Adults Happy with Weight	*Percent*	41.9		42.1	42.6	*2024*	8
1.76	Poor Physical Health: 14+ Days	*percent*	14.7			12.7	*2022*	5
1.76	Self-Reported General Health Assessment: Poor or Fair	*percent*	20.7			17.9	*2022*	5
1.47	Self-Reported General Health Assessment: Good or Better	*percent*	85.8		85.4	86	*2024*	8
1.41	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	*Percent*	37.6		38.1	38.2	*2024*	8

1.24	Life Expectancy	*years*	76		75.2	*2020-2022*	10
1.21	Poor Physical Health: Average Number of Days	*days*	4.3		4.3	*2022*	10
0.97	Adults who Feel Life is Slipping Out of Control	*Percent*	23.1		24.1	23.9 *2024*	8
0.79	Adults who Agree Vaccine Benefits Outweigh Possible Risks	*Percent*	60.8		59.8	60.4 *2024*	8

SCORE	WOMEN'S HEALTH	UNITS	LORAIN COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.53	Breast Cancer Incidence Rate	*cases/ 100,000 females*	142.9		132.3	129.8	*2017-2021*	12
2.35	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	22	15.3	20.2	19.3	*2018-2022*	12
1.41	Mammogram in Past 2 Years: 50-74	*percent*	74.4	80.3		76.5	*2022*	5
1.24	Cervical Cancer Screening: 21-65	*Percent*	82.4			82.8	*2020*	5
0.91	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	6.8		7.8	7.5	*2017-2021*	12
0.62	Mammography Screening: Medicare Population	*percent*	53		51	39	*2023*	7

Additional Demographic Data

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

Table 25: Population Size of Hospital Community by Zip Code

Zip Code	Population	Zip Code	Population
44011	25,690	44117	10,534
44022	17,009	44118	39,323
44039	37,266	44119	11,541
44040	2,857	44120	33,198
44060	59,837	44121	31,296
44070	31,764	44122	36,554
44092	16,709	44123	17,271
44094	37,700	44124	39,419
44095	32,163	44125	28,805
44102	41,880	44127	3,857
44103	13,419	44128	26,872
44104	19,808	44129	27,801
44105	32,344	44130	49,467
44106	25,926	44131	20,272
44107	49,191	44132	14,346
44108	18,700	44135	25,792
44109	37,444	44136	25,526
44110	17,069	44137	23,002
44111	39,791	44139	24,698
44112	17,532	44142	18,043
44113	21,091	44143	24,149
44115	10,323	44144	20,879
CCCHR Community (Total)	1,158,158		

Table 26: Age Profile of Hospital Community and Surrounding Geographies

Age Category	CCCHR Community	Ohio
0-4	5.2%	5.6%
5-9	5.4%	5.7%
10-14	5.7%	6.1%
15-17	3.5%	3.8%
18-20	3.9%	4.4%
21-24	4.8%	5.3%
25-34	13.5%	12.4%
35-44	12.7%	12.2%
45-54	11.3%	11.7%
55-64	13.2%	13.0%
65-74	12.0%	11.6%
75-84	6.2%	6.1%
85+	2.6%	2.2%
Median Age	41.7 years	40.5 years

Table 27: Racial/Ethnic Profile of Hospital Community and Surrounding Geographies

	CCCHR Community	Ohio	U.S.
White	57.1%	75.7%	63.4%
Black/African American	29.7%	12.8%	12.4%
American Indian/Alaskan Native	0.2%	0.3%	0.9%
Asian	3.3%	2.7%	5.8%
Native Hawaiian/Pacific Islander	<0.1%	0.1%	0.2%
Another Race	3.1%	2.1%	6.6%
Two or More Races	6.6%	6.4%	10.7%
Hispanic or Latino (any race)	7.3%	5.0%	19.0%

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

Table 28: Population Age 5+ by Language Spoken at Home for Hospital Community and Surrounding Geographies

	CCCHR Community	Ohio	U.S.
Only English	89.0%	92.8%	78.0%
Spanish	4.4%	2.3%	13.4%
Asian/Pacific Islander Language	1.3%	1.0%	3.5%
Indo-European Language	4.1%	2.8%	3.8%
Other Language	1.2%	1.1%	1.2%

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

Table 29: Household Income of Hospital Community and Surrounding Geographies

Income Category	CCCHR Community	Cuyahoga County	Ohio
Under $15,000	12.8%	12.8%	9.5%
$15,000 - $24,999	9.1%	9.1%	7.8%
$25,000 - $34,999	8.8%	8.7%	8.0%
$35,000 - $49,999	12.7%	12.5%	12.2%
$50,000 - $74,999	16.2%	16.5%	17.0%
$75,000 - $99,999	12.0%	11.9%	13.0%
$100,000 - $124,999	8.5%	8.4%	9.9%
$125,000 - $149,999	5.8%	5.8%	7.0%
$150,000 - $199,999	6.2%	6.2%	7.2%
$200,000 - $249,999	3.0%	3.0%	3.5%
$250,000 - $499,999	3.1%	3.4%	3.4%
$500,000+	1.5%	1.7%	1.6%
Median Household Income	$63,614	$60,568	$68,488

Table 30: Poverty Rates in Hospital Community and Surrounding Geographies

Zip Code	Families Below Poverty	Zip Code	Families Below Poverty
44011	3.6%	44117	7.4%
44022	2.7%	44118	9.6%
44039	4.5%	44119	18.2%
44040	3.4%	44120	16.8%
44060	3.8%	44121	12.0%
44070	7.0%	44122	6.1%
44092	4.1%	44123	15.4%
44094	3.2%	44124	3.5%
44095	3.3%	44125	15.2%
44102	25.7%	44127	32.6%
44103	32.5%	44128	21.8%
44104	48.8%	44129	7.7%
44105	26.1%	44130	7.4%
44106	19.3%	44131	3.0%
44107	8.4%	44132	20.6%
44108	27.5%	44135	19.5%
44109	21.0%	44136	3.0%
44110	28.7%	44137	20.1%
44111	16.8%	44139	3.2%
44112	24.1%	44142	6.5%
44113	20.3%	44143	4.1%
44115	58.5%	44144	11.5%
CCCHR Community (Overall)	19.9%		
Cuyahoga County	12.2%		
Lake County	4.0%		
Lorain County	9.8%		
Ohio	9.4%		
U.S.	8.8%		

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

Table 31: Educational Attainment of Hospital Community and Surrounding Geographies

	CCCHR Community	Ohio	U.S.
Less than High School Graduate	9.4%	8.6%	10.6%
High School Graduate	28.3%	32.8%	26.2%
Some College, No Degree	20.8%	19.6%	19.4%
Associate Degree	8.6%	8.9%	8.8%
Bachelor's Degree	19.4%	18.6%	21.3%
Master's, Doctorate, or Professional Degree	13.5%	11.5%	13.7%

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

Table 32: High Rent Burden in Hospital Community and Surrounding Geographies

Zip Code	Renters Spending 30% or More of Income on Rent	Zip Code	Renters Spending 30% or More of Income on Rent
44011	31.8%	44117	62.0%
44022	56.2%	44118	54.8%
44039	35.6%	44119	53.8%
44040	19.2%	44120	49.6%
44060	39.1%	44121	41.4%
44070	44.1%	44122	42.2%
44092	41.7%	44123	45.7%
44094	48.5%	44124	41.9%
44095	51.4%	44125	61.7%
44102	50.1%	44127	57.1%
44103	53.6%	44128	49.3%
44104	51.3%	44129	39.0%
44105	51.8%	44130	48.1%
44106	47.5%	44131	31.7%
44107	37.0%	44132	54.4%
44108	61.6%	44135	53.0%
44109	50.6%	44136	41.9%
44110	61.6%	44137	45.4%
44111	46.3%	44139	48.7%
44112	64.0%	44142	46.2%
44113	38.7%	44143	47.3%
44115	44.6%	44144	40.7%
Cuyahoga County	47.5%		
Lake County	46.0%		
Lorain County	46.3%		
Ohio	45.1%		
U.S.	50.4%		

All values: American Community Survey (2019-2023)

Table 33: Internet Access in Hospital Community and Surrounding Geographies

Zip Code	Households with Internet	Zip Code	Households with Internet
44011	94.0%	44117	78.2%
44022	97.9%	44118	92.3%
44039	93.4%	44119	84.6%
44040	97.6%	44120	78.9%
44060	93.6%	44121	90.6%
44070	91.3%	44122	92.8%
44092	92.2%	44123	84.4%
44094	92.1%	44124	92.2%
44095	89.5%	44125	86.7%
44102	83.7%	44127	70.3%
44103	73.3%	44128	83.4%
44104	69.3%	44129	90.3%
44105	78.8%	44130	89.8%
44106	84.6%	44131	94.3%
44107	91.6%	44132	84.6%
44108	73.3%	44135	85.2%
44109	85.0%	44136	92.0%
44110	75.5%	44137	88.0%
44111	87.8%	44139	95.5%
44112	72.8%	44142	87.9%
44113	87.5%	44143	88.9%
44115	74.6%	44144	86.6%
Cuyahoga County	87.5%		
Lake County	91.9%		
Lorain County	86.9%		
Ohio	89.0%		
U.S.	89.9%		

All values: American Community Survey (2019-2023

Appendix C: Environmental Scan and Key Findings

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

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

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

- 2023 Ohio State Health Assessment[21]
- 2023 City of Cleveland Parks and Recreation Community Needs Assessment[22]
- 2024 Cuyahoga County ADAMHS Board Needs Assessment[23]
- 2023 Cuyahoga County Planning Commission Data Book[24]
- 2022 Greater Cleveland LGBTQ+ Community Needs Assessment[25]
- Joint 2022 Cuyahoga County CHNA[26]
- 2023 Livable Cuyahoga Needs Assessment[27]
- 2022 Lake County Community Health Needs Assessment28
- 2025 Lorain County Community Health Needs Assessment29

---

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

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

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

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

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

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

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

[28] Lake County General Health District. (2022). *2022 Lake County, Ohio Community Health Needs Assessment*. Lake County General Health District. https://www.lcghd.org/wp-content/uploads/2022/10/FINAL-2022-Lake-County-Ohio-CHNA-Report_09_30_22.pdf

[29] Lorain County Public Health. (2025). *Community Health Assessment* [PDF]. Lorain County. https://www.loraincountyhealth.com/cha

Appendix D: Community Input Assessment Tools and Key Findings

Community Stakeholder Facilitation Guide

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

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

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

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

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

Section #1: Introduction

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

Section #2: Community Health Questions and Probes

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

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

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

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

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

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

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

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

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

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

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

Community Input Key Findings

A total of 14 organizations provided feedback for the CCCHR community. Interviews with each stakeholder varied by individual and the amount of feedback they provided. They generally ranged from thirty to sixty minutes. A full write up of qualitative data findings and the community stakeholder facilitation guide can be found in Appendix D.

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

- ADAMHS Board of Cuyahoga County
- ASIA (Asian Services In Action)
- Boys and Girls Clubs of Northeast Ohio
- City of Cleveland Department of Public Health
- Cleveland Clinic Children's Hospital for Rehabilitation
- Cleveland Clinic Children's
- Cuyahoga County Board of Health
- Cuyahoga Metropolitan Housing Authority
- First Year Cleveland
- Greater Cleveland Food Bank
- Lead Safe Cleveland Coalition
- LGBTQ+ Assessment Greater Cleveland / Cleveland Clinic
- NAMI Greater Cleveland
- Positive Education Program (PEP)

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

Access to Healthcare

Access to Healthcare emerged as one of the most frequently discussed priorities across stakeholder interviews for the Cleveland Clinic Children's Hospital for Rehabilitation community. Participants described how affordability, provider shortages, and transportation barriers often make it difficult for families to obtain timely and coordinated care. Families of children with complex medical, developmental, or rehabilitative needs face particular challenges, as many must navigate multiple specialists and appointments across different healthcare systems. Stakeholders noted that while the region benefits from strong hospital-based services, community-level access to pediatric, behavioral, and rehabilitative care remains limited. Insurance restrictions, long wait times, and lack of care coordination contribute to missed appointments, delayed treatment, and caregiver stress.

Key Findings

The following are highlights of participant feedback regarding Access to Healthcare:

- High costs and insurance limitations restrict access to needed care and therapies.
- Long wait times for pediatric, specialty, and behavioral health appointments.

- Transportation barriers prevent consistent attendance at therapy and medical visits.
- Limited availability of care coordination and navigation support for families.
- Workforce shortages in pediatric rehabilitation and developmental care.
- Fragmented systems lead to confusion and delayed follow-up for children with special health needs.
- Need for more community-based, family-centered, and integrated care models.

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

"Even when families have insurance, getting consistent care is difficult. Appointments take months, and transportation or scheduling issues often mean children miss needed therapies."

"Parents spend hours coordinating between specialists. There's no one helping them navigate it all."

"Families with medically complex kids need more support, someone to guide them through the system, not just more appointments."

"There are great services here, but they're not equally accessible for everyone, especially for lower-income or single-parent households."

Stakeholders agreed that Access to Healthcare for children and families within the CCCHR community is shaped by financial, logistical, and structural barriers that extend beyond the healthcare system itself. While clinical quality and specialty services are strong, equal access remains inconsistent. Participants emphasized the importance of improving care coordination, expanding transportation and telehealth options, and addressing insurance and workforce limitations. Enhancing navigation support and developing integrated, community-based care models were identified as critical strategies to reduce gaps in access, strengthen continuity of care, and improve long-term health outcomes for children and families across the region.

Behavioral Health: Mental Health and Substance Use Disorder

Behavioral Health was identified as a major area of concern among stakeholders for the CCCHR community. Participants described rising mental and emotional health needs among children, adolescents, and families, often intensified by social stress, trauma, and economic hardship. Stakeholders emphasized that behavioral health concerns are not limited to diagnosed conditions but include a broader spectrum of issues such as anxiety, depression, social withdrawal, and caregiver stress. They noted that children with developmental or physical disabilities face particular challenges in accessing behavioral health services tailored to their needs. Despite growing awareness and demand, the supply of pediatric mental health providers has not kept pace, creating long wait times and limiting access to timely intervention.

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

- Rising rates of anxiety, depression, and stress among children and families.
- Shortage of pediatric behavioral health providers and long appointment wait times.
- Limited availability of services for children with developmental or complex needs.
- Behavioral health stigma continues to discourage families from seeking help.
- Inadequate coordination between behavioral, medical, and educational systems.
- High cost and limited insurance coverage for ongoing counseling or psychiatric care.
- Strong need for family-centered, trauma-informed, and integrated behavioral health care.

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

"There are not enough pediatric behavioral health providers, especially those who understand kids with developmental or physical disabilities."

"Families are waiting months for an appointment, and by then, the crisis has already escalated."

"Stigma is still a huge barrier. Parents worry about how others will perceive their child if they ask for help."

"Behavioral health needs to be part of the care plan from the start, not something addressed after a crisis."

Stakeholders described Behavioral Health as one of the most urgent and complex challenges facing the CCCHR community. While awareness of mental health needs has improved, access to timely and appropriate services remains limited. Long wait times, workforce shortages, and limited specialized training for providers contribute to gaps in care. Families managing children with chronic or developmental conditions often experience added stress due to fragmented behavioral and medical systems. Participants emphasized that expanding access to integrated, family-centered, and culturally responsive behavioral health care is essential to improving both emotional and physical well-being for children and families across the CCCHR service area.

Chronic Disease Prevention & Management

Chronic Disease Prevention and Management were frequently discussed by stakeholders as ongoing challenges within the CCCHR community. Participants identified obesity, diabetes, and asthma as common conditions affecting both children and adults, often linked to social and environmental factors such as food insecurity, limited access to nutritious food, and inadequate opportunities for physical activity. Families caring for children with chronic or complex health needs face additional barriers, including financial stress, time constraints, and difficulty coordinating multiple specialists. Stakeholders emphasized that while hospital-based specialty care is strong, preventive education, early screening, and community wellness programs remain limited or unevenly accessible across the region.

The following are highlights of participant feedback regarding Chronic Disease Prevention and Management:

- High rates of obesity, diabetes, asthma, and related chronic conditions.
- Food insecurity and high cost of healthy food limit nutrition choices.
- Limited access to safe, affordable spaces for physical activity.
- Lack of consistent preventive education and chronic disease screening.
- Financial strain and competing priorities hinder disease management for families.
- Need for stronger coordination between medical care and community wellness programs.
- Importance of early intervention and family-centered education to prevent long-term complications.

The following are a few select quotes illustrating feedback about Chronic Disease Prevention and Management by key informants:

"Families want to help their kids eat healthy and stay active, but it's hard when food is expensive and neighborhoods don't feel safe for outdoor play."

"We're seeing chronic conditions in children earlier and more often. Prevention isn't happening soon enough."

"Nutrition education and wellness programs exist, but they're not accessible to everyone or offered consistently."

"Families with children who have multiple conditions need better coordination across care teams."

Stakeholders described Chronic Disease Prevention and Management as a major community concern that intersects closely with social and economic conditions. Limited access to affordable healthy food, safe recreational areas, and preventive education creates barriers to maintaining wellness for children and adults alike. Families managing chronic or complex conditions often face additional challenges related to cost, time, and fragmented care systems. Participants emphasized that expanding community-based prevention programs, improving coordination among providers, and integrating nutrition and physical activity supports into family care plans are essential to reducing differences in chronic disease outcomes and improving long-term outcomes in the CCCHR community.

Maternal and Child Health

Maternal and Child Health was identified as an important but unevenly addressed priority within the Cleveland Clinic Children's Hospital for Rehabilitation community. Stakeholders described persistent differences in birth outcomes, maternal health, and access to early childhood supports. Families with limited financial resources or transportation often face barriers to receiving consistent prenatal and postpartum care. Participants also noted that maternal mental health and access to parenting support are ongoing challenges, particularly for women experiencing stress related to housing instability, childcare costs,

or employment demands. While high-quality obstetric and pediatric care are available regionally, follow-up care and social supports after birth remain inconsistent.

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

- Differences in birth outcomes and maternal health.
- Gaps in access to prenatal, postpartum, and pediatric follow-up care.
- High rates of preterm birth, low birthweight, and infant mortality.
- Limited maternal mental health screening and counseling services.
- Transportation, childcare, and cost barriers reduce appointment attendance.
- Families report difficulty accessing lactation, home visiting, and parenting programs.
- Need for culturally responsive, trauma-informed, and family-centered maternal care.

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

"Many moms feel forgotten after giving birth. There's not enough support for mental health, breastfeeding, or navigating care once they go home."

"Transportation and childcare make it hard for families to keep up with well visits and postpartum care."

"Programs that provide home visits, doula support, or parenting education really help, but access is limited."

Stakeholders agreed that Maternal and Child Health remains a foundational aspect of community well-being and an area requiring stronger system coordination. While the region benefits from advanced medical care, many families experience barriers that extend beyond the clinical setting, including social, economic, and emotional stressors. Participants emphasized the need to expand maternal mental health services, home visiting programs, and culturally relevant family supports that address both medical and social needs. Strengthening partnerships among hospitals, public health agencies, and community-based organizations was identified as critical to improving birth outcomes, supporting healthy child development, and ensuring equal maternal and infant care across the CCCHR service area.

Autism Spectrum Disorder

Stakeholders consistently identified Autism Spectrum Disorder (ASD) as a significant and growing focus area within the Cleveland Clinic Children's Hospital for Rehabilitation community. Participants described a strong need for early identification, access to specialized diagnostic services, and expansion of behavioral and educational supports for children with autism and their families. Many noted that while the region benefits from the presence of the Cleveland Clinic Children's Center for Autism, families still experience long wait times for evaluation and treatment, limited access to therapy in community settings, and challenges navigating multiple systems of care.

Stakeholders emphasized the importance of early intervention and continuity of care, noting that families often face barriers transitioning between early childhood, school-

based, and adult service systems. Access to Applied Behavioral Analysis (ABA), occupational therapy, speech therapy, and behavioral supports was frequently cited as limited by insurance coverage, workforce shortages, and geographic disparities in service availability. Several participants also discussed the emotional and financial strain families face in coordinating care, describing a need for more family-centered case management, peer support networks, and community outreach programs tailored to diverse populations.

Finally, stakeholders highlighted opportunities to improve understanding and inclusion for individuals with ASD within schools, healthcare systems, and the broader community. They called for greater collaboration between healthcare providers, educators, and social service organizations to build more seamless systems of support for all populations. Overall, feedback reflected both recognition of the strong clinical and research infrastructure available through Cleveland Clinic and the continued need to expand accessible, comprehensive autism services that address the medical, behavioral, educational, and social needs of children and families across the CCCHR service area.

The following are highlights of participant feedback regarding Autism Spectrum Disorder:

- Increasing demand for ASD screening, diagnosis, and treatment services.
- Long wait times for evaluation and specialized therapy appointments.
- Limited availability of Applied Behavioral Analysis (ABA) and developmental therapies.
- Insurance and cost barriers to ongoing behavioral and therapeutic care.
- Shortages of trained providers across behavioral and rehabilitative disciplines.
- Gaps in continuity during transitions between early intervention, school-based, and adult services.
- Need for more family-centered case management and caregiver support.
- Importance of culturally responsive outreach and community inclusion initiatives.

The following are a selection of quotes illustrating feedback about ASD by key informants:

"Families wait months just to get an autism evaluation, and by the time they do, they've already lost valuable time for early intervention."

"There are excellent programs in the area, but not enough capacity to meet the growing need."

"Care coordination is exhausting for parents. They're managing doctors, therapists, and schools with little guidance or support."

"We need more awareness and inclusion within schools and the community so kids with autism can thrive beyond clinical settings."

Health-Related Social Needs

Health-Related Social Needs were consistently identified by stakeholders as underlying factors that shape nearly every other health outcome in the Cleveland Clinic Children's Hospital for Rehabilitation community. Participants described how poverty, housing instability, food insecurity, and transportation barriers limit families' ability to prioritize health and maintain consistent care. Many families caring for children with special health or developmental needs struggle to balance medical expenses with basic living costs, leading to financial and emotional strain. Stakeholders emphasized that when basic needs go unmet, preventive care and therapy appointments are often postponed or skipped, perpetuating differences in health outcomes and delaying progress in rehabilitation and recovery.

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

- Persistent poverty, unemployment, and housing instability affect family well-being.
- Food insecurity and lack of affordable nutritious options are widespread concerns.
- Transportation barriers limit access to appointments, education, and employment.
- Families experience high financial stress balancing health costs and basic needs.
- Safety concerns and limited recreational infrastructure impact children's physical activity.
- Difficulty navigating fragmented social services and eligibility systems.
- Need for improved screening, referrals, and cross-sector collaboration to address social needs.

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

"When families are worried about rent, food, or transportation, their child's therapy is the first thing to get pushed aside."

"There are resources available, but families often don't know where to start or how to access them."

"Transportation is a constant barrier. Missed appointments are not about neglect, they're about access."

"Housing conditions and neighborhood safety affect a child's ability to recover and stay healthy."

Stakeholders described Health-Related Social Needs as deeply intertwined with healthcare access, chronic disease management, and overall family stability. Economic hardship, housing and food insecurity, and inadequate transportation create ongoing barriers that disproportionately affect families of children with chronic or rehabilitative needs. Participants emphasized that meeting these social needs is essential for improving engagement in care and reducing differences in health outcomes. Expanding social needs screening in clinical settings, strengthening care coordination, and increasing partnerships with community-based organizations were identified as essential strategies for improving family stability and supporting long-term health and well-being within the CCCHR service area.

Appendix E: Impact Evaluation

Actions Taken Since Previous CHNA

Cleveland Clinic Children's Hospital for Rehabilitation (CCCHR) offers services dedicated to the medical, surgical, and rehabilitative care of infants, children, and adolescents. CCCHR's previous Implementation Strategy Report (ISR) outlined a plan for addressing the following priorities identified in the 2022 CHNA: Access to Healthcare, Behavioral Health, Chronic Disease Prevention and Management, Maternal and Child Health (including Autism Spectrum Disorder), and Health-related Social Needs.

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

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

Access to Affordable Healthcare

Actions and Highlighted Impacts:

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

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

C. Through funding sources, CCCHR provided transportation for families to assist in securing medical appointments.

Behavioral Health

Actions and Highlighted Impacts:

A. Through a chronic pain management program, CCCHR made recommendations to patients for alternative pain management strategies, reducing patient exposure to opioids

B. CCCHR provided services for neonatal abstinence syndrome (NAS) in infants exposed to substances before birth, reducing negative health outcomes.

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

Chronic Disease Prevention and Management

Actions and Highlighted Impacts:

A. CCCHR provided health education and community outreach events related to development disabilities and congenital conditions in children.

B. Through Cleveland Clinic's Children's Wellness Center, educated children and families through the *Be Well Kids* programs, improving physical activity and nutrition.

C. CCCHR provided nutritional counseling, occupational therapy, physical therapy, psychology, recreational therapy, and speech/language therapy in outpatient settings to children who required focused medical and developmental attention, including Down's syndrome clinic, and neurodevelopmental clinic for children with chronic disease.

Maternal and Child Health

Actions and Highlighted Impacts:

A. CCCHR provided neonatal abstinence syndrome (NAS) services for infants exposed to substances before birth (see Behavioral Health).

B. The hospital provided infant safe sleep education and support, feeding issues education for families.

Specialty Care- Autism Spectrum Disorder

Actions and Highlighted Impacts:

A. Through the Center for Autism, CCCHR offered a continuum of services for children with Autism Spectrum Disorder (ASD), including speech therapy and outpatient behavioral therapy to increase coordinated efforts for children to achieve their highest level of functioning.

B. Through the Lerner School for Autism, a chartered, non-public day school for students from the age of first diagnosis until 21 years, CCCHR provided education and treatment for children with ASD.

C. CCCHR provided technical assistance and professional consulting to Autism programs nationwide with the goal in improving health outcomes for children with ASD.

Health-Related Social Needs

Actions and Highlighted Impacts:

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

B. The hospital continued to provide services of Cleveland Clinic RN Care Coordinators and Social Workers for post-hospital care and home adjustment for children and families.

C. CCCHR expanded trauma-informed care training opportunities for nurses and staff.

D. Through funding sources, CCCHR provided families with medical equipment, eyeglasses, payment of utilities and rent to ensure safe housing and support.

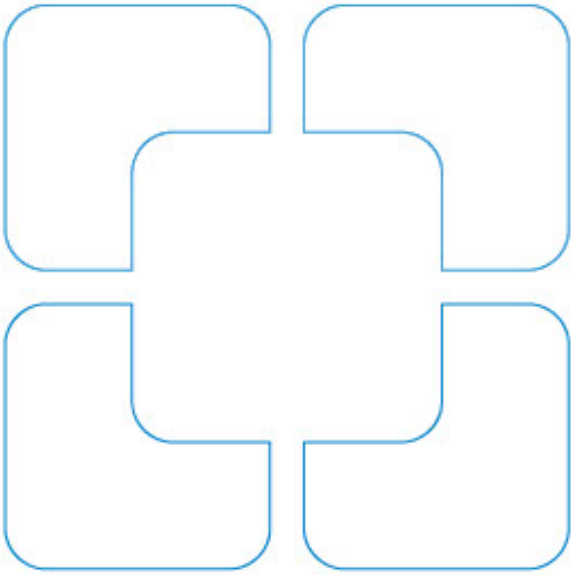
E. CCCHR continued discussions between public schools and CCCHR for continuum of care, therapy, and clinical services. CCCHR staff met with home teachers to support education and assimilation.

Appendix F: Acknowledgements

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

Authors for this report include:

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



clevelandclinic.org/**CHNAreports**

25-CCC-6446158

Cleveland Clinic Children's
Hospital for Rehabilitation

Implementation Strategy Report

2025

CLEVELAND CLINIC CHILDREN'S HOSPITAL FOR REHABILITATION
2025 Community Health Needs Assessment
Implementation Strategy Report for Years 2026 – 2028

Table of Contents

Cleveland Clinic Children's Hospital for Rehabilitation Implementation Strategy Report..... 193

I. Introduction and Purpose..... 193
A. Description of Hospital 193

II. Cleveland Clinic Children's Hospital for Rehabilitation Community Definition194

III. How Implementation Strategy was Developed..... 196

IV. Summary of the Community Health Needs Identified..... 196

V. Needs Hospital Will Address..... 196
A. Access to Healthcare 197
B. Behavioral Health.....197
C. Chronic Disease Prevention and Management 198
D. Maternal and Child Health 199
Specialty Care - Autism Spectrum Disorder 200
E. Health-Related Social Needs 200

Cleveland Clinic Children's Hospital for Rehabilitation Implementation Strategy Report

I. Introduction and Purpose

This written plan is intended to satisfy the requirements set forth in Internal Revenue Code Section 501(r)(3) regarding community health needs assessments and implementation strategies. The overall purpose of the Implementation Strategy is to align the hospital's limited resources, program services, and activities with the Cleveland Clinic Children's Hospital for Rehabilitation findings of the Community Health Needs Assessment (CHNA). The Implementation Strategy Report (ISR) includes the priority community health needs identified during the 2025 CHNA for Cleveland Clinic Children's Hospital for Rehabilitation. This report includes strategies for years 2026 through 2028.

The ISR serves as the foundational framework for each hospital's community health efforts and guides how Cleveland Clinic translates identified community needs into coordinated action. The ISR aligns hospital-level strategies with enterprise-wide community priorities, including food security, maternal and child health, and lead safety, ensuring that local initiatives contribute to broader system goals.

Community engagement is embedded throughout the Community Health Needs Assessment process, from the data collection and prioritization of needs to the design, implementation, and evaluation of strategies, so that community voice meaningfully informs decision-making at every stage. Cleveland Clinic recognizes that healthy communities are achieved through collective action and that sustained improvements require strong partnerships among hospitals, public health agencies, community-based organizations, and community members. These strategies reflect a shared commitment to collaborative, cross-sector approaches, recognizing that no single organization can address complex community health challenges alone.

A. Description of Hospital

The Cleveland Clinic Children's Hospital for Rehabilitation (CCCHR) is a 25 bed[30] hospital located in Cleveland, Ohio that offers inpatient care, day hospital care and a comprehensive range of inpatient and outpatient services. The hospital is accredited by the Commission on Accreditation of Rehabilitation Facilities and is a CARF-accredited, freestanding pediatric rehabilitation hospital. It offers specialized pediatric and rehabilitative services, including behavioral health, neurology, nephrology, and occupational, physical, and speech therapy. The Cleveland Clinic Children's Center for Autism is also housed within CCCHR. The Center for Autism provides innovative, community-based interventions for children with autism while advancing professional training and research.

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

As part of the broader Cleveland Clinic health system, CCCHR upholds the tripartite mission of caring for life, researching for health, educating those who serve. Cleveland Clinic is a nonprofit, multispecialty academic medical center that integrates hospital-based services with innovative research and the training of future healthcare professionals. Currently, with more than 83,000 caregivers, 23 hospitals, and 280 outpatient facilities around the world, Cleveland Clinic is recognized as one of the world's leading healthcare systems. Its collaborative, patient-centered model of care promotes improved outcomes and enhances quality of life for patients both locally and internationally.

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

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

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

CCCHR is a trusted part of the community and continues to grow and improve to meet the needs of its patients. To learn more, visit:
my.clevelandclinic.org/pediatrics/locations/rehabilitation-hospital/about

II. Cleveland Clinic Children's Hospital for Rehabilitation Community Definition

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

Figure 1: CCCHR Community Definition

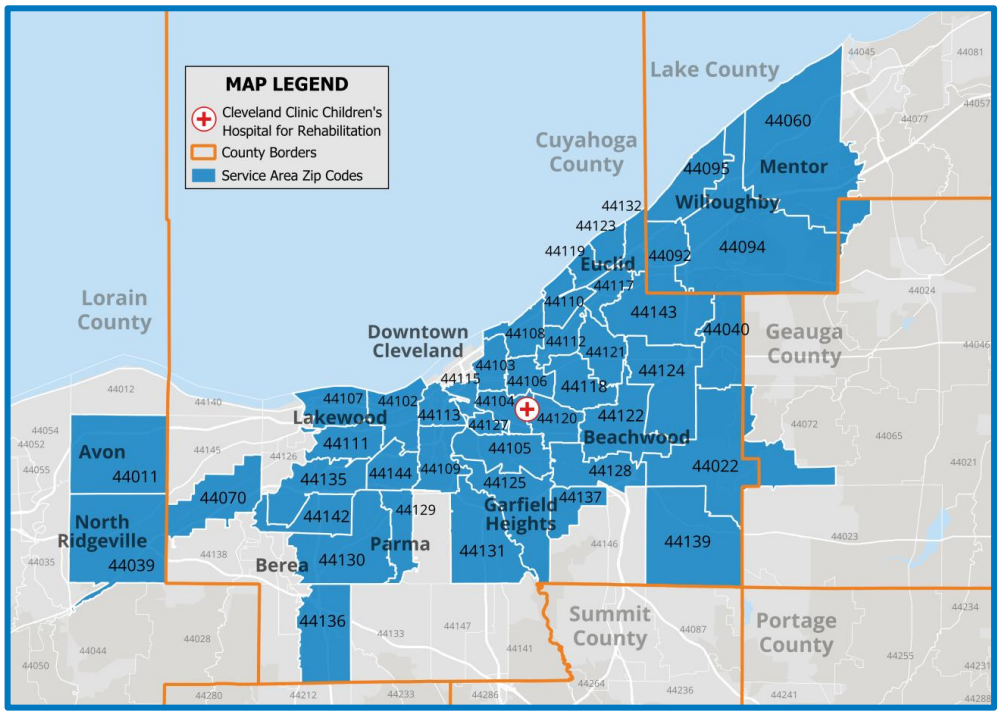


Table 1: CCCHR Community Definition

Zip Code	Postal Name	Zip Code	Postal Name	Zip Code	Postal Name
44011	Avon	44108	Cleveland	44125	Cleveland
44022	Chagrin Falls	44109	Cleveland	44127	Cleveland
44039	North Ridgeville	44110	Cleveland	44128	Cleveland
44040	Gates Mills	44111	Cleveland	44129	Cleveland
44060	Mentor	44112	Cleveland	44130	Cleveland
44070	North Olmsted	44113	Cleveland	44131	Independence
44092	Wickliffe	44115	Cleveland	44132	Euclid
44094	Willoughby	44117	Euclid	44135	Cleveland
44095	Eastlake	44118	Cleveland	44136	Strongsville
44102	Cleveland	44119	Cleveland	44137	Maple Heights
44103	Cleveland	44120	Cleveland	44139	Solon
44104	Cleveland	44121	Cleveland	44142	Brookpark
44105	Cleveland	44122	Beachwood	44143	Cleveland
44106	Cleveland	44123	Euclid	44144	Cleveland
44107	Lakewood	44124	Cleveland		

III. How Implementation Strategy was Developed

This Implementation Strategy was developed by members of leadership at Cleveland Clinic Children's Hospital for Rehabilitation representing several departments of the organization, including clinical administration, medical operations, nursing, and social work. This team incorporated input from the hospital's community and local nonprofit organizations to prioritize selected strategies and determine possible collaborations. Leadership at the CCCHR will utilize this Implementation Strategy to determine whether changes should be made to better address the health needs of its communities.

IV. Summary of the Community Health Needs Identified

Cleveland Clinic Children's Hospital for Rehabilitation's prioritized community health needs as determined by analyses of quantitative and qualitative data from the 2025 CHNA include:

- Access to Healthcare
- Behavioral Health
- Chronic Disease Prevention and Management
- Maternal and Child Health (including Autism Spectrum Disorder)
- Health-Related Social Needs

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

V. Needs Hospital Will Address

Each Cleveland Clinic hospital has adopted and is implementing an Implementation Strategy to address the significant community health needs identified through the 2025 CHNA, in accordance with the requirements of Internal Revenue Service (IRS) Section 501(r). This Implementation Strategy outlines the hospital's planned actions for the 2026–2028 implementation period and describes how identified community health needs will be addressed through hospital-led programs, services, and partnerships.

Implementation efforts focus on addressing underlying structural and social factors that influence health; strengthening and sustaining trust with community members, partners, and stakeholders; incorporating community input into the development and implementation of strategies; and monitoring and evaluating the effectiveness of programs and initiatives over time.

The strategies included in this ISR reflect collaborative efforts between CCCHR and local nonprofit, public health, and community-based organizations. These coordinated

initiatives are intended to improve health outcomes within the community the hospital serves.

A. Access to Healthcare

The 2025 CHNA for the Cleveland Clinic Children's Hospital for Rehabilitation identifies Access to Healthcare as a central concern, with families facing cost barriers, insurance limitations, and delays in approvals, especially for rehabilitative and behavioral health services. Stakeholders noted transportation challenges, long wait times, and provider shortages that disproportionately affect low-income families and those living far from major care centers. Parents of children with complex needs often struggle to coordinate multiple appointments across fragmented systems, while language, cultural, and digital barriers further hinder access. Stakeholders emphasized the need for integrated, family-centered care models, expanded navigation supports, and improved telehealth and outreach. Secondary data show high child insurance coverage but limited primary care availability in Lake County and elevated CHI scores in Cleveland zip codes with concentrated access challenges.

Access to Healthcare Initiatives for 2026-2028 include:

Access to Healthcare Initiatives Including Collaborations, Resources Allocated, and Anticipated Impacts

A. **Initiative:** Continue to provide Patient Financial Advocates to support patients in evaluating eligibility for financial assistance or public health insurance programs.

   Anticipated Impacts: Increase the proportion of eligible individuals who are enrolled in assistance programs, increase access to healthcare.

B. **Initiative:** Through funding sources, provides transportation for families to assist securing medical appointments.

   Anticipated Impacts: Overcome geographical and transportation barriers.

B. Behavioral Health

The 2025 CHNA for the CCCHR community identifies Behavioral Health as a growing priority, with rising anxiety, depression, and behavioral challenges among children and adolescents driven by social isolation, family stress, trauma, and complex developmental needs. Stakeholders reported long wait times, provider shortages, and limited inpatient or step-down options, forcing some youth to rely on emergency departments. Families also face barriers related to insurance coverage, transportation, stigma, and difficulties coordinating care across medical, educational, and behavioral systems. Participants emphasized the need for integrated, family-centered models, expanded outpatient and crisis services, and stronger school-based supports. Secondary data show improving trends in youth substance use and some mental health indicators, yet high-risk groups continue to face disproportionate challenges, reflected in high Mental Health Index scores across many Cleveland-area ZIP codes.

Behavioral Health Initiatives for 2026-2028 include:

Behavioral Health Initiatives Including Collaborations, Resources Allocated, and Anticipated Impacts

A. **Initiative:** Through a chronic pain management program, make recommendations to patients for alternative pain management strategies.

   Anticipated Impacts: Reduce the prescription of opioids, decrease healthcare expenses, reduce patient exposure to opioids.

B. **Initiative:** Treat neonatal opioid withdrawal syndrome (NOWS) in infants exposed to substances before birth.

   Anticipated Impacts: Reduce side effects and negative health outcomes associated with NOWS.

C. **Initiative:** Implement a Partial Hospitalization Program (PHP) for patients.

   Anticipated Impacts: Improve outpatient access to needed therapies, increase awareness of treatment for behavioral health conditions.

C. Chronic Disease Prevention and Management



The 2025 CHNA for the CCCHR community identifies Chronic Disease Prevention and Management as a major challenge for both children and adults, driven by barriers such as transportation difficulties, financial strain, and limited understanding of disease management. Stakeholders highlighted diabetes, asthma, obesity, and hypertension as prevalent conditions requiring long-term coordination, yet noted gaps in care continuity between healthcare, schools, and community systems. Families of children with complex needs often struggle to navigate multiple providers and inconsistent access to nutrition and wellness supports. Participants emphasized the importance of early intervention, culturally responsive education, and stronger care coordination. Secondary data reflect persistent concerns around nutrition and food access, high child food insecurity rates, and concentrated food hardship in several Cleveland zip codes.

Chronic Disease Prevention and Management Initiatives for 2026-2028 include:

Chronic Disease Prevention and Management Initiatives Including Collaborations, Resources Allocated, and Anticipated Impacts

A. **Initiative:** Provide health promotion messaging, health education, and community outreach events related to development disabilities and congenital conditions.

Anticipated Impacts: Improve early detection of long-term outcome of pediatric development disabilities and congenital conditions.

B. Initiative: Through Cleveland Clinic's Children's Wellness Center, educate children and families through the Be Well Kids programs.

Anticipated Impacts: Improve physical activity, improve nutrition, decrease stress levels, decrease smoking and vaping.

C. Initiative: Continue to offer nutritional counseling, occupational therapy, physical therapy, psychology, recreational therapy, and speech/language therapy in outpatient settings to children who require focused medical and developmental attention, including Down's syndrome clinic, and neurodevelopmental clinic for children with chronic disease.

Anticipated Impacts: Improve outpatient access to needed therapies.

D. Maternal and Child Health 

The 2025 CHNA for the CCCHR community identifies Maternal and Child Health as an important but unevenly addressed need, with stakeholders highlighting differences in birth outcomes, maternal health complications, and access to early childhood supports. Families facing financial hardship, housing instability, or transportation challenges often struggle to maintain consistent prenatal and pediatric care, while gaps in postpartum support, especially for maternal mental health and breastfeeding, remain significant. Stakeholders emphasized the need for culturally relevant care, home visiting programs, and stronger coordination for families of children with developmental or medical needs. Secondary data show high infant mortality, elevated rates of low birthweight and preterm births and persistently high teen birth rates. Autism Spectrum Disorder was also noted as a growing concern, marked by rising prevalence, long wait times, limited therapy access, and significant caregiver strain, underscoring the need for earlier diagnosis, coordinated services, and family-centered support across medical, educational, and social systems.

Maternal and Child Health Initiatives for 2026-2028 include:

Maternal and Child Health Initiatives Including Collaborations, Resources Allocated, and Anticipated Impacts

A. Initiative: Treat neonatal opioid withdrawal syndrome (NOWS) in infants exposed to substances before birth (see Behavioral Health).

Anticipated Impacts: Increase the number of mothers who receive adequate prenatal care.

B. Initiative: Provide infant safe sleep education and support and feeding issues education for families.

Anticipated Impacts: Reduce infant mortality, improve the preterm birth rate, decrease sleep related infant deaths.

Specialty Care - Autism Spectrum Disorder

Cleveland Clinic's state-of-the-art autism facility is housed at Cleveland Clinic Children's Hospital for Rehabilitation Campus. This facility is dedicated to treatment, education, and research for children, adolescents, young adults, and families experiencing autism spectrum disorders. The Center for Autism offers outpatient diagnostic services and treatment based on applied behavioral analysis. Children with ASD frequently suffer from other developmental, psychiatric, neurological, chromosomal, and genetic disorders and have higher annual medical costs than children without ASD.

Autism Spectrum Disorder Initiatives for 2026-2028 include:

Autism Spectrum Disorder Initiatives Including Collaborations, Resources Allocated, and Anticipated Impacts

A. **Initiative:** Through the Center for Autism, offer a continuum of services including speech therapy and outpatient behavioral therapy.

   Anticipated Impacts: Increase access to coordinated behavioral health services, increase the percentage of children who achieve the highest level of functioning.

B. **Initiative:** Through the Lerner School for Autism, a chartered, non-public day school for students from diagnosis -21 years, provide education and treatment for children with Autism Spectrum Disorder (ASD).

   Anticipated Impacts: Increase the percentage of children who achieve the highest level of functioning, decrease the level of specialized educational placement required by students.

C. **Initiative:** Provide technical assistance and consulting to Autism programs nationwide.

   Anticipated Impacts: Improve health outcomes for children with ASD nationwide.

E. Health-Related Social Needs

The 2025 CHNA for the Cleveland Clinic Children's Hospital for Rehabilitation identifies Health-Related Social Needs as significant barriers to family health and care continuity. Stakeholders emphasized how poverty, housing instability, food insecurity, and limited transportation disrupt medical follow-up and strain families caring for children with special health or developmental needs. Unstable housing, unsafe environments, and unreliable transportation particularly hinder attendance at ongoing therapy and rehabilitation. Families also struggle to navigate complex service systems and often lack awareness of available supports. Participants stressed the need for coordinated, family-centered approaches that integrate medical and social services, including case

management and community health workers. Secondary data reinforce these concerns, showing high child poverty rates, substantial financial burdens for basic needs, and elevated levels of youth disconnection and family instability across Cuyahoga and Lake counties.

Health-Related Social Needs Initiatives for 2026-2028 include:

Health-Related Social Needs Initiatives Including Collaborations, Resources Allocated, and Anticipated Impacts

A. **Initiative:** Continue Cleveland Clinic referral data platform, Unite Us, to coordinate services and ensure optimal communication, connecting residents with essential community resources.

   Anticipated Impacts: Enables gap closure, ensuring that social needs such as food assistance, family support, housing assistance, and mental health services are resolved.

B. **Initiative:** Continue Cleveland Clinic RN Care Coordinators and Social worker Community Health Workers and/or the co-location of community organizations.

   Anticipated Impacts: Ensure connection to medical, social, and behavioral services.

C. **Initiative:** Continue trauma informed care training for nurses and staff.

   Anticipated Impacts: Decrease trauma related issues for children.

D. **Initiative:** Through funding sources, provide families with medical equipment, eyeglasses and payment of utilities, and rent.

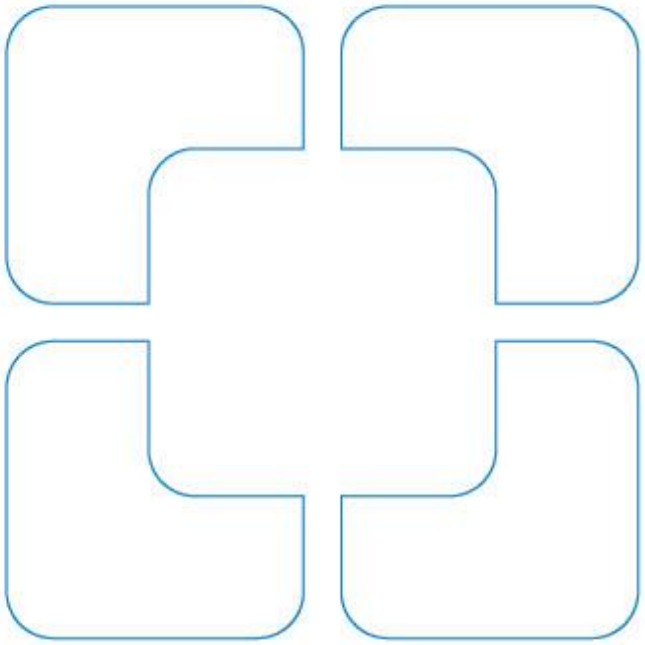
   Anticipated Impacts: Ensure provision of community resources and safety.

E. **Initiative:** Continue discussions between public schools and CCCHR for continuum of care, therapy, and clinical services.

   Anticipated Impacts: Ensure connection to medical, social, and behavioral services.

While this ISR outlines specific strategies and programs identified to address the 2025 CHNA prioritized areas of Access to Healthcare, Behavioral Health, Chronic Disease Prevention and Management, Maternal and Child Health (including Autism Spectrum Disorder), and Health-Related Social Needs, it does not reflect all the work being done by Cleveland Clinic Children's Hospital for Rehabilitation to improve community health. Through this iterative process, opportunities are identified to grow and expand existing work in prioritized areas as well as implement additional programming in new areas. These ongoing strategic conversations will allow Cleveland Clinic Children's Hospital for Rehabilitation to build stronger community collaborations and make smarter, more targeted investments to improve the health of the people in the communities they serve.

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



clevelandclinic.org/**CHNAreports**

25-CCC-6446244