Cleveland Clinic
Rehabilitation Hospital
In affiliation with Select Medical

Fairhill

Community Health Needs Assessment

2025

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Cleveland Clinic Rehabilitation Hospital Fairhill
2025 Community Health Needs Assessment

Introduction

This Community Health Needs Assessment (CHNA) was conducted by the newly established Cleveland Clinic Rehabilitation Hospital Fairhill (CCRH Fairhill or "the hospital") to identify significant community health needs and to inform development of an Implementation Strategy to address current needs.

The hospital is a joint venture between Cleveland Clinic health system and Select Medical. As part of the broader Cleveland Clinic health system, CCRH Fairhill 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 CCRH Fairhill, contributes to the system-wide advancement of clinical research and medical innovation. Patients at CCRH Fairhill benefit from access to novel treatments, clinical trials, and evidence-based practices developed and shared across the Cleveland Clinic network.

Select Medical is one of the largest providers of post-acute care encompassing three areas of expertise: critical illness recovery, inpatient medical rehabilitation, and outpatient physical therapy, all of which are delivered and supported by talented healthcare professionals across the U.S. Additional information about Select Medical is available at selectmedical.com/.

CHNA Background

As part of its mission to improve health and well-being in the communities it serves, CCRH Fairhill 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.

CCRH Fairhill Community Definition

The community definition describes the zip codes where approximately 75% of discharges from the hospital are anticipated to originate from for the newly established CCRH Fairhill. 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 neighborhoods that comprise the community definition.

Figure 1: CCRH Fairhill Community Definition

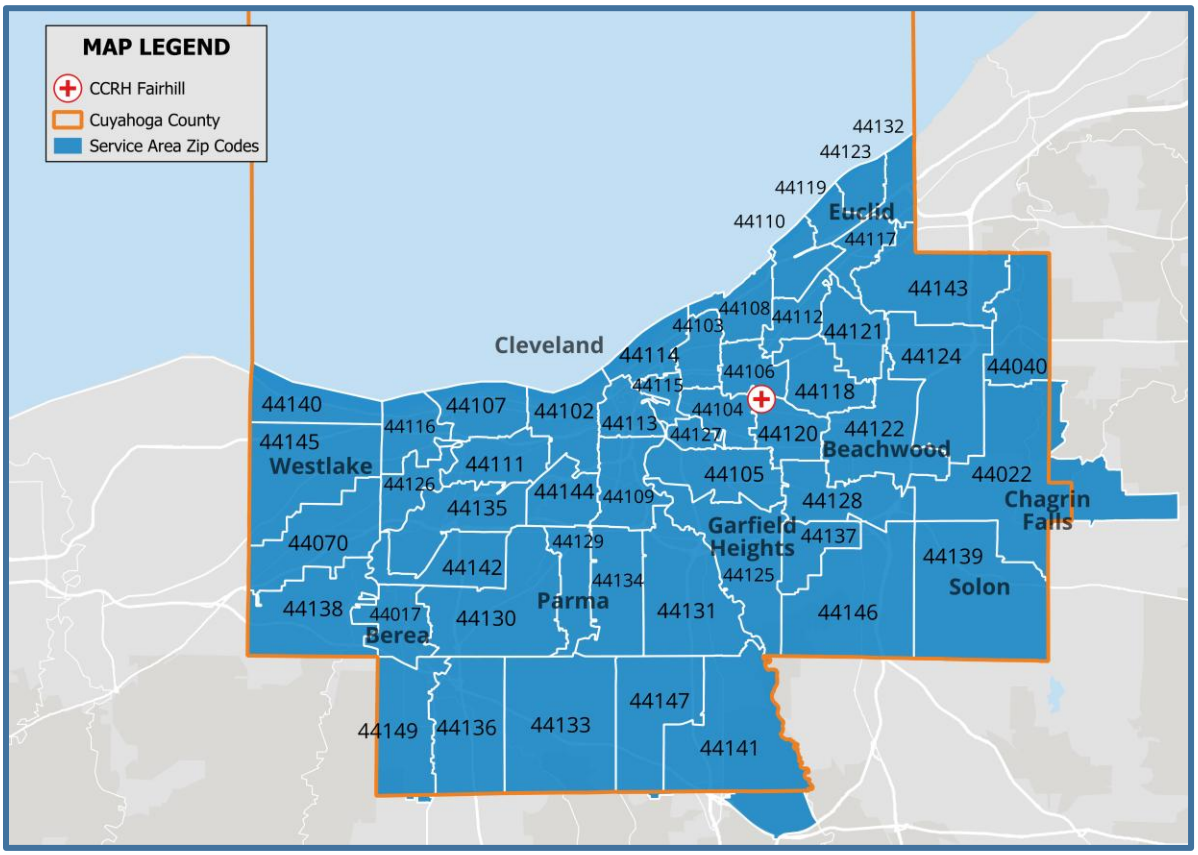


Table 1: CCRH Fairhill Community Definition

Zip Code	Municipality	Zip Code	Municipality
44011	Avon	44118	Cleveland
44022	Chagrin Falls	44129	Cleveland
44039	North Ridgeville	44130	Cleveland
44040	Gates Mills	44092	Wickliffe
44060	Mentor	44107	Lakewood
44070	North Olmsted	44142	Brookpark
44092	Wickliffe	44070	North Olmsted
44094	Willoughby	44039	North Ridgeville
44095	Eastlake	44095	Eastlake
44102	Cleveland (Detroit-Shoreway)	44122	Beachwood
44103	Cleveland (Hough)	44143	Cleveland
44104	Cleveland (Kinsman)	44094	Willoughby
44105	Cleveland (South Broadway)	44124	Cleveland
44106	Cleveland (University)	44060	Mentor
44107	Lakewood	44011	Avon
44108	Cleveland (Forest Hills)	44022	Chagrin Falls
44109	Cleveland (Brooklyn-Centre)	44136	Strongsville
44110	Cleveland (South Collinwood)	44131	Independence
44111	Cleveland (Jefferson)	44139	Solon
44112	Cleveland	44040	Gate Mills
44113	Cleveland (Tremont)		
44115	Cleveland (Industrial Valley)		
44117	Euclid		
44118	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 zip-code of the hospital community area. Data were compared to national benchmarks, state averages, and historical trends to identify areas of concern. The analysis reinforced three key health priorities: Access to Healthcare, Adult Health, and Community Safety, 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 three prioritized needs prioritized in this 2025 CHNA process.

Across communities, consistent themes emerged: cost barriers and provider shortages limit healthcare access; chronic disease management is challenged by food insecurity and inadequate recreational infrastructure; and topics related to community safety, 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 CCRH Fairhill community. These conversations included individuals from 15 organizations who spoke directly to the needs within the community. Participants represented sectors including public health, mental health, housing, food access, and other community organizations.

Conversations with stakeholders across the CCRH Fairhill community highlighted pressing needs related to Access to Healthcare, Adult Health, and Community Safety. Stakeholders emphasized that residents often delay care because of affordability, insurance gaps, and difficulty navigating the healthcare system, with transportation and language barriers creating additional obstacles. Concerns about adult health centered on the growing burden of chronic disease, limited access to preventive care, and the risks of isolation among older adults, particularly those living alone without sufficient supports. Community safety was described as a daily challenge in some neighborhoods, where gun

violence, overdoses, and crime contribute to chronic stress, limit outdoor activity, and undermine community trust. Stakeholders called for greater investment in prevention efforts and coordinated community partnerships that address both clinical services and the broader conditions shaping health outcomes.

Summary

2025 Prioritized Health Needs

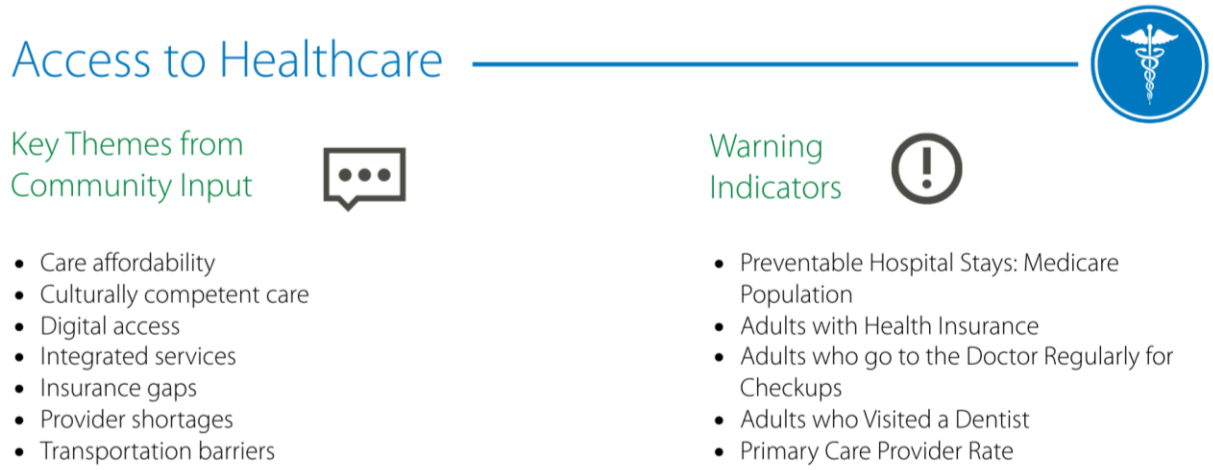
CCRH Fairhill's 2025 Community Health Needs Assessment affirms its commitment to addressing the three core health priorities based on a synthesis of primary data in the form of community stakeholder interviews, secondary indicators from national and state data sources, and a regional environmental scan.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



These priorities reflect persistent and deeply interconnected challenges, such as provider shortages, care affordability, chronic disease burden, and the health impacts of poverty, neighborhood conditions, and safety. Community input, coupled with data showing that Cuyahoga 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 CCRH Fairhill.

The three prioritized community health needs identified in this 2025 CCRH Fairhill 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 consistent and pressing concern across stakeholder interviews, reflecting ongoing challenges with affordability, availability, and system navigation. Participants highlighted that while healthcare infrastructure is present, longstanding barriers continue to prevent equal access, particularly for low-income populations, immigrants, and older adults. Cost was identified as a major obstacle, with stakeholders pointing to the burden of co-pays, prescription expenses, and follow-up visits that often discourage residents from seeking needed care. Even insured individuals were described as struggling to afford regular services, leading to delayed treatment and reliance on emergency departments.

Geographic and transportation barriers were also repeatedly raised as limiting timely access to care. Residents in some neighborhoods face long or complicated commutes, which when combined with mobility challenges, further restrict utilization of routine and preventive services. Stakeholders emphasized that convenience and time strongly influence care-seeking behavior, with many residents opting out of care when appointments are too difficult to reach or when scheduling systems are perceived as complex. Gaps in culturally and linguistically appropriate care were described as compounding these barriers, particularly for populations with limited trust in healthcare systems.

Stakeholders further underscored the need for integrated approaches that bring medical, behavioral, and social services together in accessible community settings. Co-located models of care were viewed as a way to reduce fragmentation and help residents navigate complex systems while addressing underlying social needs such as housing, food, and behavioral health. Building trust, diversifying the healthcare workforce, and investing in care that is culturally aware are opportunities that were highlighted as essential to strengthening engagement and improving outcomes. Overall, the interviews reflect a clear call for affordable, accessible, and coordinated care delivery that reduces systemic barriers and better meets the needs of the community.

Secondary indicators from trusted national and state data sources reinforce and provide further contextualization of the insights provided by community stakeholders. Several key

indicators within the Healthcare Access category revealed concerning trends. For example, adults in Cuyahoga County are less likely than the overall Ohio population to go to the doctor regularly for checkups (63.3% vs. 65.2%) or go to the dentist (43.3% vs. 44.3%). Among Medicare recipients in particular, Cuyahoga County experiences a higher rate of preventable hospital stays than Ohio (3,677 vs. 3,269 discharges per 100,000). The county's Black/African American Medicare recipients are 50% more likely to be hospitalized for preventable issues (5,651 discharges per 100,000).

Geospatial data from Conduent HCI's Community Health Index (CHI) further underscore the magnitude of access challenges. The CHI, estimates health risk based on socioeconomic conditions associated with preventable hospitalizations and poor health outcomes. Across the CCRH Fairhill community, the zip codes with the greatest healthcare needs are 44115 (Cleveland, Industrial Valley) and 44104 (Cleveland, Kinsman), with CHI values of 99.9 and 99.8, respectively. 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: Adult Health

Adult Health

Key Themes from Community Input

- Community education
- Disease prevalence
- Food insecurity
- Medication costs
- Screening gaps
- Stress and poverty
- Unsafe neighborhoods

Warning Indicators

- Adults 20+ with Diabetes
- Adults with Cancer (Non-Skin) or Melanoma
- Adults who Frequently Cook Meals at Home
- All Cancer Incidence Rate
- Breast Cancer Incidence Rate
- Cancer: Medicare Population
- Cervical Cancer Incidence Rate
- Chronic Kidney Disease: Medicare Population
- Hyperlipidemia: Medicare Population
- Ischemic Heart Disease: Medicare Population
- Osteoporosis: Medicare Population
- People 65+ Living Alone
- People 65+ Living Below Poverty Level
- Prostate Cancer Incidence Rate
- Rheumatoid Arthritis or Osteoarthritis: Medicare Population
- Self-Reported General Health: Good or Better
- Stroke: Medicare Population

Adult Health outcomes were highlighted by stakeholders as a health concern shaped by a mix of chronic disease burdens, preventive care gaps, and social and cultural barriers to the healthcare system. Common concerns include high rates of hypertension, diabetes, heart disease, obesity, and infectious diseases. Respondents noted that preventive health practices such as screenings and wellness visits are often underutilized, in part because of low health literacy, cultural differences in approaches to care, and a lack of trust in

preventive medicine when individuals do not feel sick. Transportation, language barriers, and the availability of providers who are culturally aware were consistently cited as barriers to accessing routine care.

In addition, stakeholders identified factors among specific populations that result in reduced or delayed care. Isolation among older adults emerged as a pressing issue, contributing to depression, stress, and delayed management of health needs. Cultural preferences, such as women seeking female providers for reproductive and preventive services, were also identified as limiting timely access when options are unavailable. Stakeholders highlighted the importance of health education, early detection, and integrated care that addresses both physical and behavioral health needs. They also pointed to the role of strong family networks within some communities as protective factors, while cautioning that the lack of self-care and overwork in these populations often lead to poor long-term health outcomes.

Overall, Adult Health in the community is influenced not only by the prevalence of chronic and infectious conditions but also by systemic and cultural barriers that prevent consistent engagement in preventive and wellness practices. Addressing these issues will require targeted strategies such as expanding culturally competent services, improving access to female providers, reducing transportation barriers, and investing in community-based education and screenings. Respondents stressed that integrated and collaborative approaches, including partnerships with local hospitals, health departments, and social service providers, are essential to improving adult health outcomes in the region.

Secondary data highlights several pressing concerns related to adult health in Cuyahoga County. Wellness and lifestyle factors ranked as the sixth highest scoring health topic, with nutrition and healthy eating close behind, ranked ninth. Consumer data reveal that adults in the county are more likely to rely on fast food and less likely to cook meals at home compared to nearly all other U.S. counties. This trend is compounded by food access challenges, particularly in the CCRH Fairhill community. According to Conduent HCI's Food Insecurity Index, ZIP codes 44104 and 44115 show the greatest need for improved food access, scoring 100 and 99.9 respectively.

Cancer also poses a significant health challenge. The county experiences elevated incidence rates for both prostate and breast cancer relative to national averages, prostate cancer occurs at a rate 23% higher, and breast cancer is 5% more common. While screening rates meet or exceed national benchmarks, mortality rates tell a different story. Black/African American residents of Cuyahoga County experience significantly higher mortality rates from both prostate and breast cancer compared to the county average, despite lower incidence rates.

Chronic conditions such as diabetes, heart disease, and stroke further burden the adult population. Nearly a quarter of Medicare recipients in the county are affected by diabetes, with the rate rising to 35% among Black/African American beneficiaries. Chronic Kidney Disease, often linked to unmanaged diabetes, affects this group at a rate 50% higher than the county average (30.0% vs. 20.0%). Stroke mortality stands at 40.8 per 100,000, lower than the state average but still above the Healthy People 2030 goal of 33.4. This trend is rising.

Older adults face unique challenges as well. Ranked as the fourth highest scoring health need (score: 1.60), older adult health is impacted by social and economic factors. Over one-third of residents aged 65 and older live alone, and 12.3% live below the federal poverty level, both figures surpass national averages. These circumstances, coupled with transportation and care coordination barriers, increase the risk of unmanaged chronic illness. Additionally, adult day care services in Cuyahoga County are notably expensive, consuming 13.4% of a typical household's income, which presents a significant financial strain for families seeking long-term care support.

Prioritized Health Need #3: Community Safety

Community Safety

Key Themes from Community Input

- Gun violence
- Substance use
- Unsafe environments
- Fear and stress
- Poverty
- Barriers to care related to stigma
- Social isolation
- Impaired driving

Warning Indicators

- Age-Adjusted Death Rate due to Firearms
- Age-Adjusted Death Rate due to Unintentional Injuries
- Age-Adjusted Drug and Opioid-Involved
- Alcohol-Impaired Driving Deaths
- Overdose Death Rate
- Death Rate due to Drug Poisoning
- Severe Housing Problems
- Adults who Binge Drink
- Adults who Drink Excessively
- Age-Adjusted Death Rate due to Unintentional Poisonings
- Age-Adjusted Death Rate due to Falls
- Death Rate due to Injuries
- Severe Housing Problems
- Substantiated Child Abuse Rate

Community Safety was described by stakeholders as a persistent concern. Gun violence, crime, and exposure to unsafe environments were raised as daily realities in some neighborhoods, creating chronic stress and negatively impacting both physical and mental health. Several respondents noted that children and families in affected communities live with a heightened sense of fear, which limits outdoor activity, undermines community trust, and compounds issues already present due to poverty and underinvestment. Safety was also connected to broader environmental risks such as lead exposure, housing quality, and limited access to safe and healthy recreational spaces.

Substance use, particularly related to opioids, fentanyl, and alcohol, was also described as a major driver of safety concerns. Stakeholders identified overdoses and alcohol-impaired driving deaths as pressing public health issues that destabilize families and neighborhoods. Barriers to prevention include limited culturally competent services, stigma, and gaps in treatment and harm reduction approaches. Participants stressed the need for upstream prevention efforts, stronger school and community partnerships, and accessible recovery supports that reduce risk and encourage early intervention. They also called for coordinated strategies that address safety to prevent substance use across the

lifespan, beginning with youth prevention programs and extending to older adults who may experience isolation and vulnerability.

Overall, stakeholders highlighted that Community Safety is inseparable from the social and economic context of residents' lives. Exposure to violence, substance misuse, and unsafe environments erodes trust and wellbeing while also straining healthcare and social services. Respondents emphasized the importance of investing in prevention, improving access to recovery resources, and fostering partnerships across public health, education, and community organizations to create safer, healthier neighborhoods.

Health-related social needs indicators, across prevention and safety, education, economy, and community, rank among the highest areas of concern in Cuyahoga County. Notably, the Economy (score: 1.90) and Education (score: 1.72) were among the top three quality-of-life categories identified in the analysis, highlighting key opportunities for improvement within the CCRH Fairhill community.

Violence and crime rates are especially concerning. Cuyahoga County's violent crime rate (856.5 per 100,000 residents) is more than double the state average, and its homicide rate (20.7 per 100,000) is similarly elevated. Firearm-related deaths (20.2 per 100,000) further compound the community safety crisis, placing the county in the highest quartile nationally for firearm-related fatalities. These figures underscore the impact of violence on both mortality and community trauma.

Secondary data indicates that substance use and related risks are notably high in Cuyahoga County. The drug poisoning death rate (45.5 per 100,000) and the percentage of alcohol-related driving fatalities (42.5%) both rank in the highest quartile among U.S. counties. Additionally, binge drinking rates are elevated, and alcohol involvement in driving deaths is among the highest nationwide.

Prioritized Health Needs in Context

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

Secondary Data Overview

Demographics and Socioeconomic Drivers of Health

The demographics of a community significantly impact its health profile.[1] Different cultural and socioeconomic groups may have unique needs and require varied approaches to health improvement efforts. The following section explores the demographic profile of the CCRH Fairhill community 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.[2] 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 (zip code and/or county) depending on data availability. When available, comparisons to county, state, and/or national values are provided. It should be noted that county level data may mask issues at the zip code level in many communities. While indicators may be strong when examined at a higher level, zip code level analysis can reveal differences in health outcomes.

All demographic and socioeconomic 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 CCRH Fairhill Community

According to the 2024 Claritas Pop-Facts® population estimates, the CCRH Fairhill community has approximately 1,158,158 residents. The median age in the hospital community is 41.4. Similar to the rest of Ohio, most individuals fall within the 25 to 74 age range.

The racial composition of the community is predominantly White (57.3%), which is significantly lower than the state average of 75.7%. Black/African American residents make up 29.2% of the population—higher than both the state (12.8%) and national (12.4%) averages. Hispanic/Latino individuals account for 7.3% of the community.

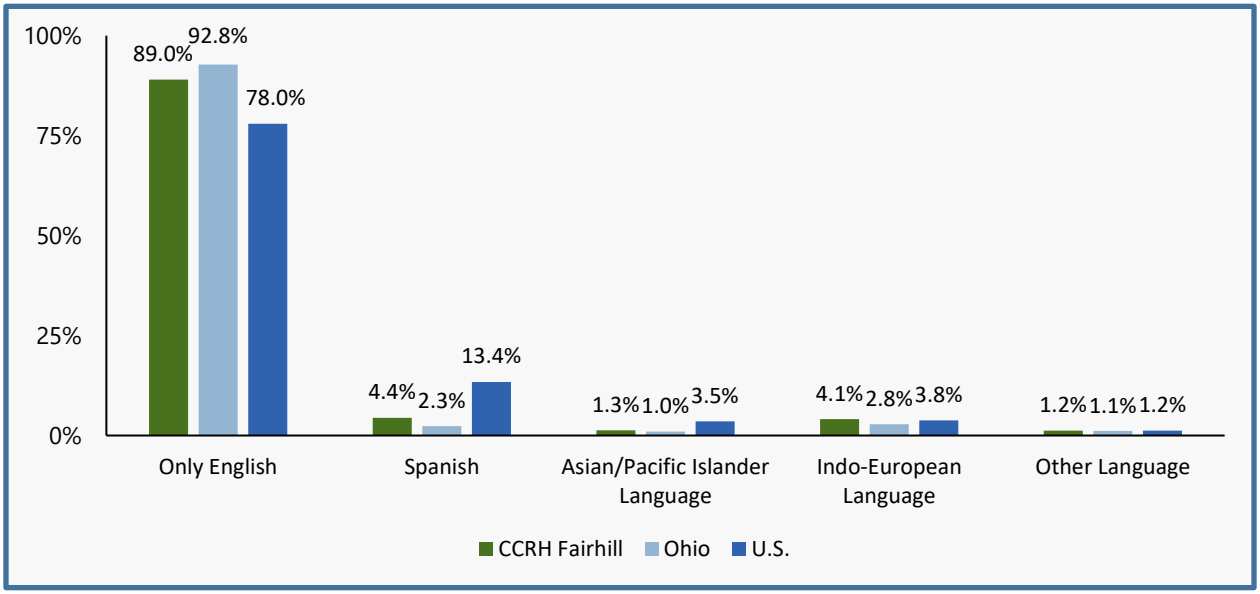
As shown in Figure 2, 88.5% of residents aged five and older primarily speak English at home. This rate is higher than the national average (78.0%) but lower than Ohio's overall

[1] National Academies Press (US); 2002. 2, Understanding Population Health and Its Determinants. Available from: https://www.ncbi.nlm.nih.gov/books/NBK221225/
[2] World Health Organization. Social Determinants of Health. https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1

rate (92.8%). Spanish is spoken at home by 4.3% of the community, compared to 2.8% statewide.

Understanding countries of origin and language spoken at home can help inform the cultural and linguistic context for the health and public health system. Primary language spoken in the home can also be a proxy for acculturation into the community.

Figure 2: Population 5+ by Language Spoken at Home: Hospital, State, and U.S. Comparisons



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

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

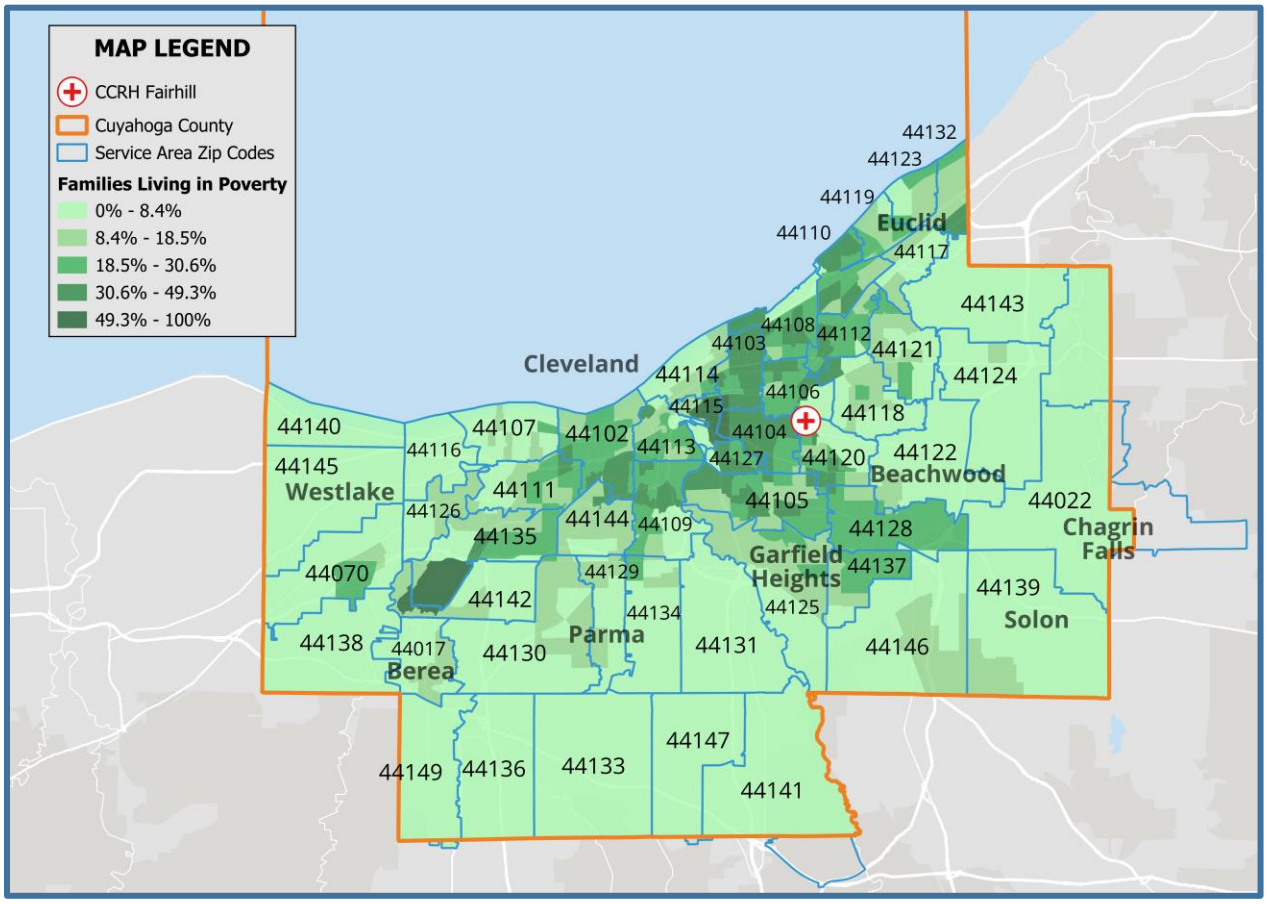
Income and Poverty

The median household income in the CCRH Fairhill community is $60,568, lower than the state of Ohio ($68,488), and the national median ($78,538).

Federal poverty thresholds, set annually by the U.S. Census Bureau, vary based on family size and the ages of household members. In the CCRH Fairhill community, 12.2% of families live below the poverty level—higher than the state average (9.4%). Within this community, ZIP code 44115 has the highest concentration of poverty, with over half of families (58.5%) living below the poverty line (see Figure 3).

Income has been shown to be strongly associated with morbidity and mortality, influencing health through various clinical, behavioral, social, and environmental factors. Those with greater wealth are more likely to have higher life expectancy and reduced risk of a range of health conditions including heart disease, diabetes, obesity, and stroke. Poor health can also contribute to reduced income by limiting one's ability to work.[4]

Figure 3: Families Living Below Poverty



Service area, census tract, zip code, and state values: Claritas Pop-Facts® (2024 population estimates)

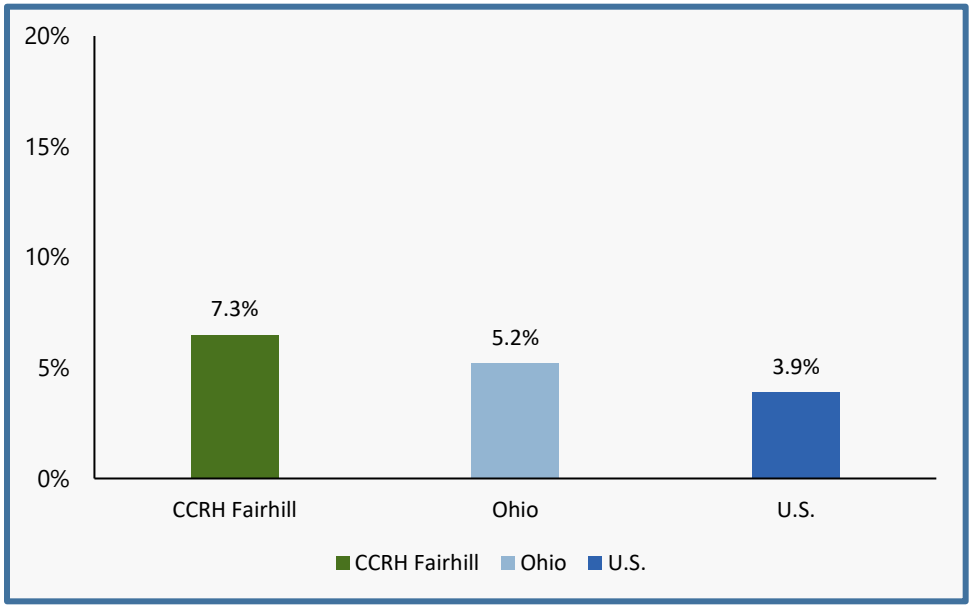
U.S. value: American Community Survey five-year (2019-2023) estimates

Education and Employment

A majority of residents in the CCRH Fairhill community have earned at least a high school diploma (90.6%), closely aligning with Ohio's rate (91.4%) and the national average (89.4%). Higher education attainment—including Bachelor's, Master's, Doctorate, and Professional degrees—is consistent with levels seen in Cuyahoga County and the state of Ohio.

Ohio's unemployment rate is 5.2%, noticeably above the national average of 3.9%. The CCRH Rehab community faces an even greater challenge, with unemployment reaching 7.3%.

Figure 4: Population 16+ Unemployed: Hospital, State, and U.S. Comparisons



Service area 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.[3] 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.[4]

Housing and Built Environment

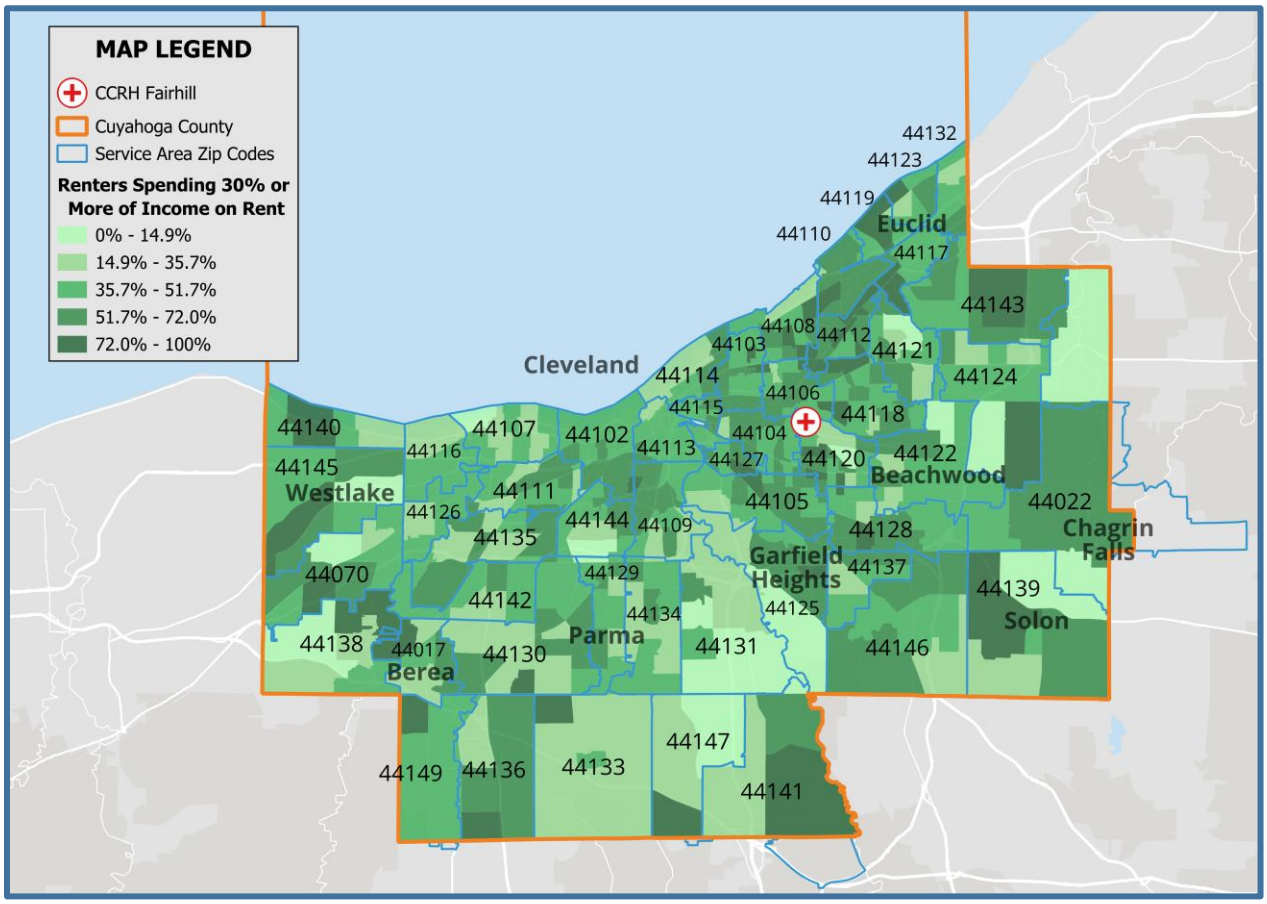
Safe, stable, and affordable housing provides a critical foundation for health and wellbeing. In Cuyahoga County, 15.9% of households experience severe housing problems. These issues include overcrowding, excessive housing costs, and the absence of basic amenities such as a kitchen or plumbing.

Housing costs in particular a burdensome across the county. Nearly half of renters in Cuyahoga (47.5%) spend at least 30% of their income on rent (Figure 5).

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

[4] 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: Renters Spending 30% Or More Of Household Income on Rent



Census tract and zip code values: 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. While 87.5% of households in Cuyahoga County have internet access, significant disparities exist at the neighborhood level. In ZIP code 44127, within the CCRH Fairhill community, only 70.3% of households have internet access.

Community Health Indices

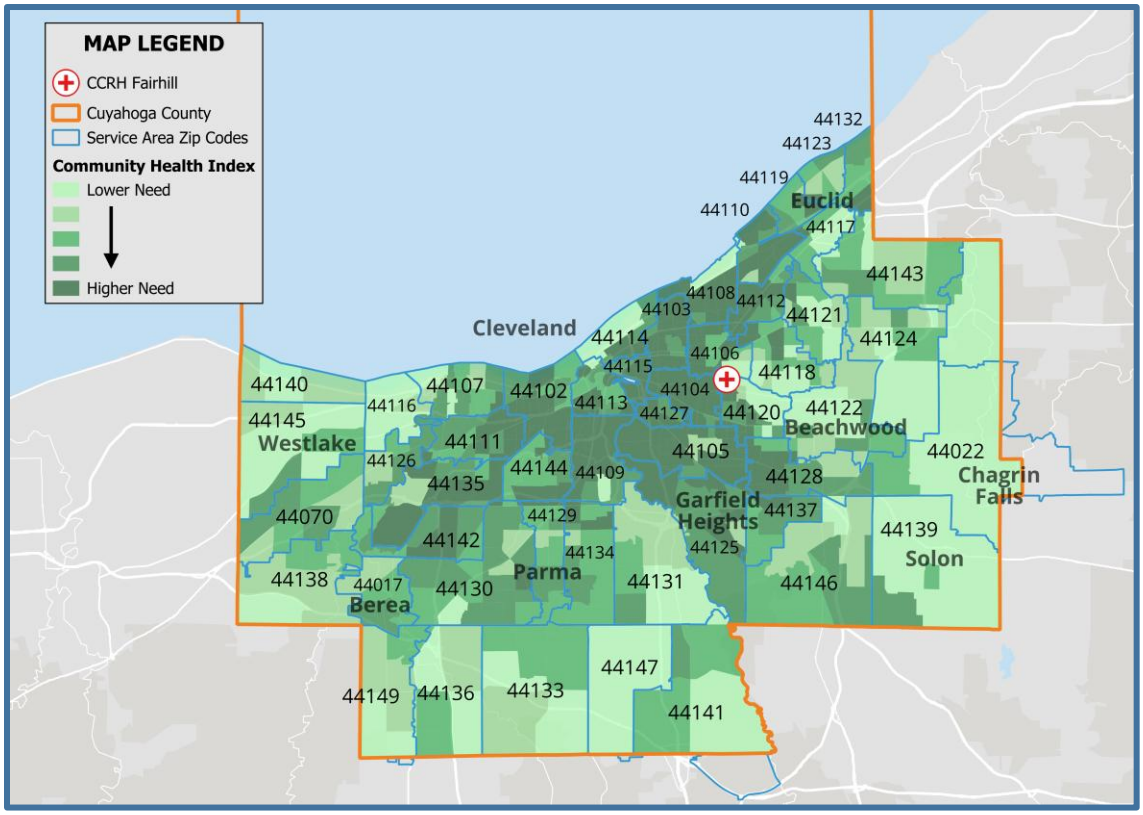
A map index that visualizes social and economic drivers of health at a specific geographic level serves as a critical decision-making tool by highlighting localized differences in health outcomes that may be obscured in broader geographic analyses. The three indices below highlight differences in community health outcomes, mental health outcomes, and food insecurity for the CCRH Fairhill 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 socioeconomic 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 CCRH Fairhill community, as indicated by the darkest shade of green. At the zip code level, 44115 (Cleveland, Industrial Valley) and 44104 (Cleveland, Kinsman) have the highest index values, at 99.9 and 99.8, respectively. See Appendix B for additional details about the CHI and a table of CHI values for each zip code in the community.

Figure 6: Community Health Index: CCRH Fairhill Community by Census Tract

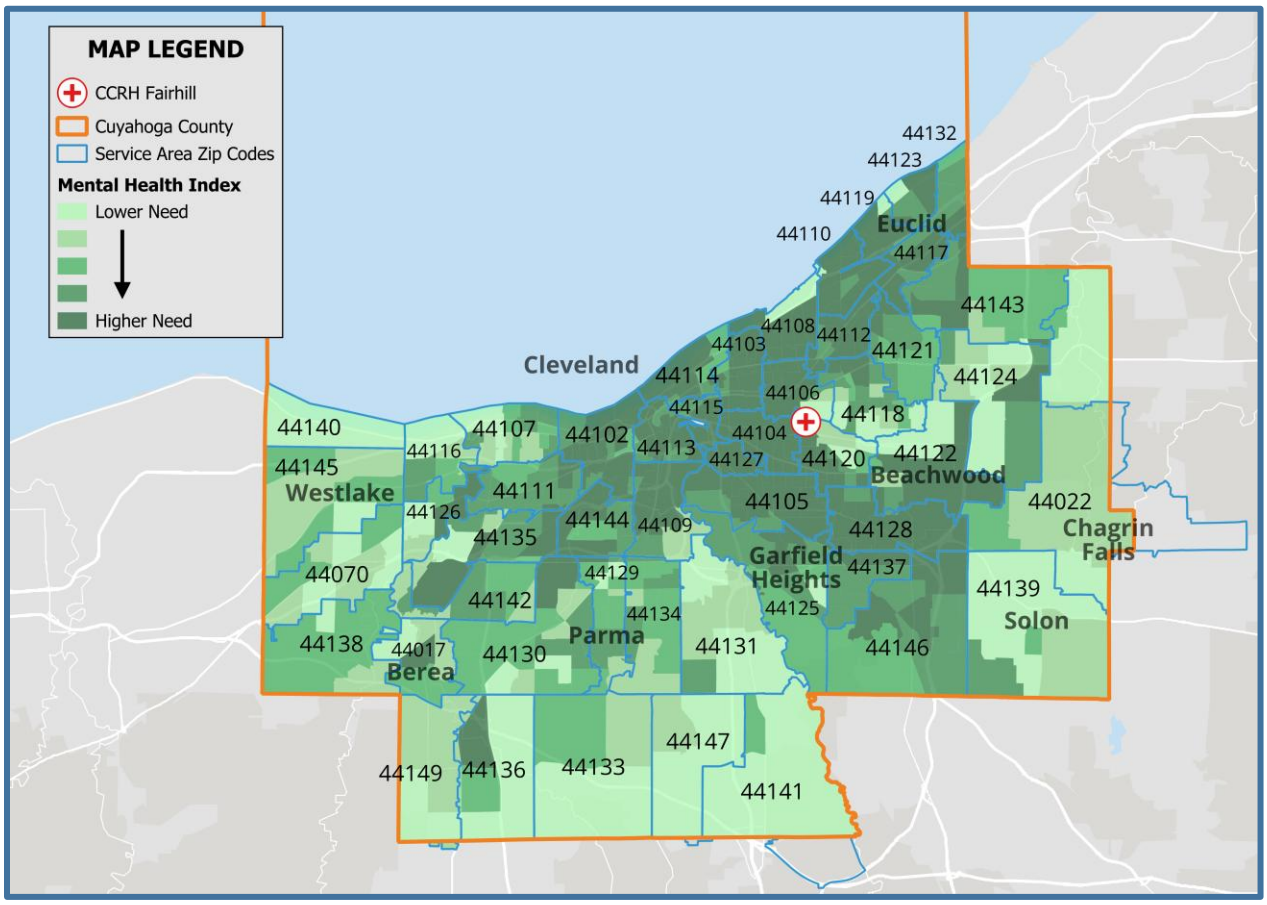


Mental Health Index

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 socioeconomic 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 CCRH Fairhill community, as indicated by the darkest shade of green. See Appendix B for additional details about the MHI and a table of MHI values for each zip code in the CCRH Fairhill community.

Figure 7: Mental Health Index: CCRH Fairhill Community by Census Tract

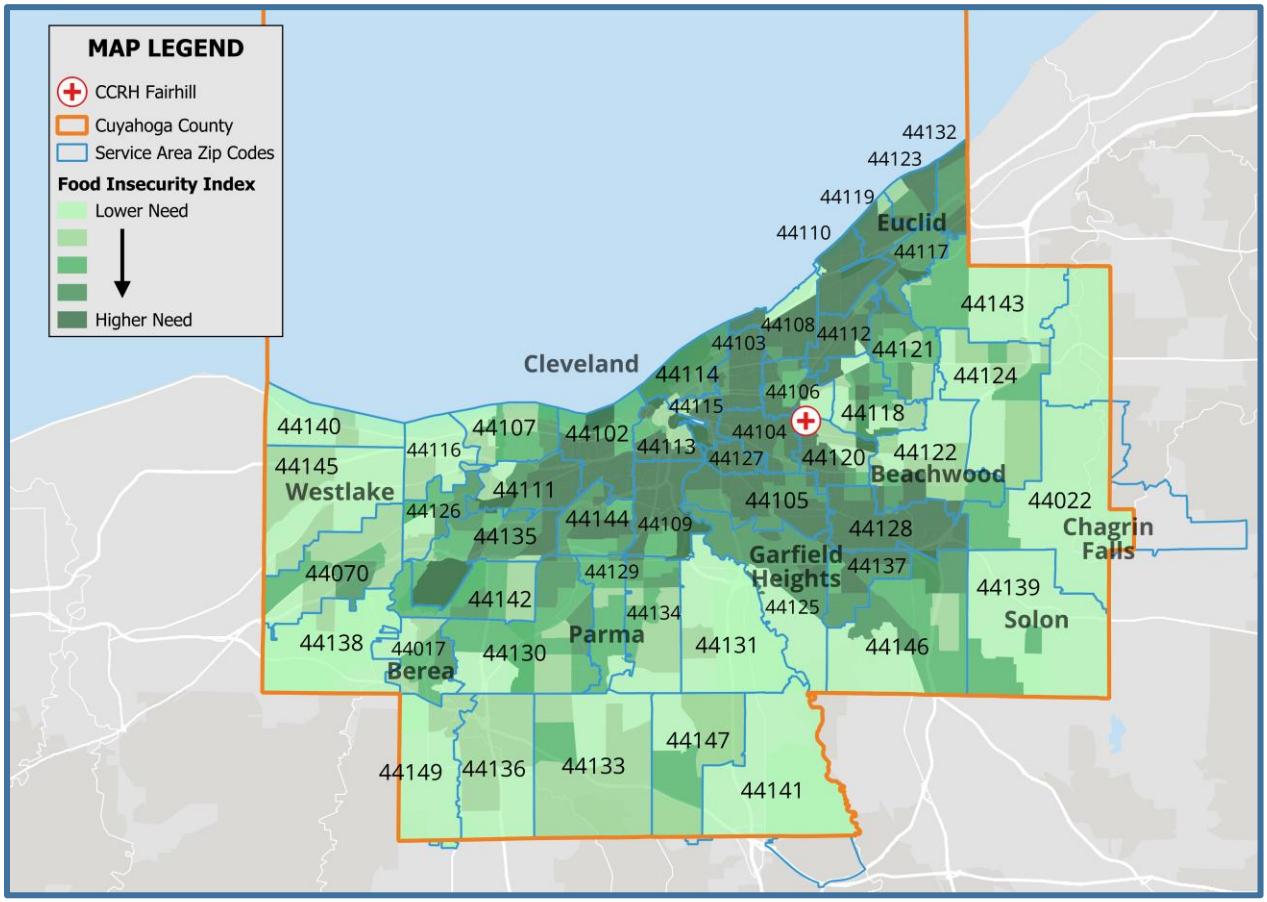


Food Insecurity Index

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 socioeconomic data that is 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 CCRH Fairhill community, as indicated by the darkest shade of green. See Appendix B for additional details about the FII and a table of FII values for each zip code and census tract in the hospital community.

Figure 8: Food Insecurity Index: CCRH Fairhill Community by Census Tract



Other Community Assessment and Improvement Plans

An environmental scan of recent community health assessments, partner reports, and improvement plans relevant to the hospital's community were researched and reviewed. Findings from this environmental scan reinforced the relevance of the three prioritized health needs identified in the 2025 CHNA by other Select Hospitals in the region. 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[5]

The following points summarize the key alignment between the 2023 Ohio State Health Assessment and CCRH Fairhill'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.
- Adult Health:
  - Statewide increases in diabetes and continued high rates of heart disease and hypertension.
  - Obesity and poor nutrition are identified as key contributors to chronic conditions.
- Community Safety:
  - Ongoing challenges related to poverty, housing affordability and quality, food insecurity, and transportation.
  - Significant unmet mental health needs and elevated levels of substance use, including youth drug use and adult overdose deaths.

2023 City of Cleveland Parks and Recreation Community Needs Assessment[6]

- 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

[5] Ohio Department of Health. (2023). *Ohio State Health Assessment 2023*. Ohio University; Ohio Department of Health. Retrieved from Ohio Department of Health website.
[6] 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

2024 Cuyahoga County ADAMHS Board Needs Assessment[7]

- 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[8]

- 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[9]

- Promote a culture of respect, empathy, and mutual support within and beyond the LGBTQ+ community
- Implement and enforce anti-discrimination laws related to healthcare, workplace rights, reproductive and family rights, identification, housing, and taxation
- Combat community helplessness by offering clear, actionable solutions and encouraging engagement
- Expand access to community education in health, civic matters, cultural awareness, and emergency preparedness

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[7] 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

[8] 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?

[9] 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

Joint 2022 Cuyahoga County CHNA (Collaborating Organizations: University Hospital, Cuyahoga County Board of Health, and the City of Cleveland Department of Health)[10]

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[11]

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
- 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

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[10] 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

[11] 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

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[12]

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

Primary Data Overview

Community Stakeholder Conversations

A total of 15 organizations provided feedback for the hospital's 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:

- ADAHMS Board
- ASIA (Asian Services In Action)
- Benjamin Rose Institute on Aging
- Cleveland Department of Public Health
- Cleveland Metropolitan Housing Authority
- Cuyahoga County Board of Health
- Esparanza
- Greater Cleveland Food Bank
- NAMI Greater Cleveland
- LGBTQ+ Assessment Greater Cleveland / Cleveland Clinic

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

- Neighborhood Family Practice
- City of Cleveland Division of Fire
- Towards Employment
- Positive Education Program
- Lead Safe

Across stakeholder interviews conducted for the 2025 Community Health Needs Assessment, Access to Healthcare, Adult Health, and Community Safety consistently emerged as urgent challenges. These areas were described as deeply interconnected, with affordability and community-level conditions shaping outcomes across the lifespan. Participants emphasized that without coordinated strategies that address both clinical care and the broader environments in which people live, work, and age, differences in health outcomes will continue to persist.

Access to Healthcare was described as a critical and enduring concern. Stakeholders pointed to affordability, insurance gaps, long wait times, and provider shortages as persistent barriers, even for those with coverage. Transportation challenges, geographic isolation, and digital access issues further limited utilization. Mistrust in providers and the lack of culturally and linguistically responsive care discouraged regular engagement with the healthcare system, resulting in greater reliance on emergency services. Participants emphasized the importance of expanding integrated and community-based care models that co-locate health, behavioral, and social services in accessible settings.

Adult Health concerns were closely tied to the burden of chronic disease, differences in cancer outcomes, and the challenges of aging. Diabetes and hypertension rates were identified as high across the region. Food insecurity and dietary behaviors, including limited home cooking and high fast-food use, were linked to these outcomes and concentrated in neighborhoods with the greatest barriers to healthy food access. For older adults, social isolation and increasing cost of living were highlighted as barriers to maintaining health and safety.

Community Safety also emerged as a pressing theme, with stakeholders connecting violence, substance use, and unsafe environments to overall health and wellbeing. Gun violence, daily exposure to crime, and unsafe housing conditions were described as drivers of chronic stress and mistrust. Alcohol-impaired driving and opioid overdoses were noted as major concerns, contributing to preventable deaths and instability for families and neighborhoods. Stakeholders called for stronger prevention efforts, culturally relevant harm reduction strategies, and expanded recovery supports, while also emphasizing the need for coordinated community partnerships that promote safer environments and address risks across the lifespan.

Priority Area	Key Quote	Additional Context
Access to Healthcare	"People avoid going to the doctor because they cannot afford the co-pays or the prescriptions, even when they have insurance."	This reflects a widespread concern among stakeholders that affordability remains a barrier even for insured residents. Limited resources, coupled with transportation challenges and long wait times, result in delayed care and greater reliance on emergency departments. The need for more affordable, culturally relevant, and integrated services was repeatedly emphasized.
Adult Health	"Our older adults are often isolated, and when they live alone it becomes a safety issue, especially with falls and no one there to help."	Stakeholders connected social isolation and aging to increased risks of injury, depression, and unmanaged chronic conditions. In Lake County, deaths due to falls are especially high, while in Cuyahoga County the cost of adult day care further limits access to supportive services.
Community Safety	"Gun violence and overdoses are what we see most, and they create constant fear for families in these neighborhoods."	Safety concerns were closely tied to both violence and substance use. Stakeholders described how exposure to crime, shootings, and opioid overdoses destabilizes communities, heightens stress, and undermines trust. Alcohol-impaired driving and unsafe environments were also noted as major contributors to preventable harm, underscoring the call for prevention, harm reduction, and stronger community partnerships.

Prioritization Methodology

The CCRH Fairhill 2025 Community Health Needs Assessment (CHNA) affirmed its focus on the three core health priorities identified in this CHNA through a comprehensive and data-driven prioritization process. This decision was guided by a 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 the areas of Access to Care, Adult Health, and Community Safety. 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, these three health needs were prioritized for the 2026–2028 Implementation Strategy.

Collaborating Organizations

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.

Community Partners and Resources

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

Federally Qualified Health Centers and Health Departments

Federally Qualified Health Centers (FQHCs)[13] 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 the hospital's, community health services are further supported by other local public health agencies as well.

Other Community Resources

A network of agencies, coalitions, and organizations provides a broad array of health and social services within the region. 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 serve as a vital referral tool. Additional information is available at www.211oh.org.

Comments Received on Previous CHNA

CCRH Fairhill is a newly opened facility as of Fall 2025, therefore no previous CHNAs have been completed to receive community feedback. For more information regarding Cleveland Clinic Community Health Needs Assessments and Implementation Strategy reports, please visit clevelandclinic.org/CHNAreportsor contact CHNA@ccf.org.

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

Request for Public Comment

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

Appendices Summary

A. Hospital Community Definition

B. Secondary Data Methodology and Secondary Data

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

C. Environmental Scan Methodology 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: Community Definition

The community definition describes the zip codes where approximately 75% of discharges from the hospital are anticipated to originate from for the newly established CCRH Fairhill. Figure 9 shows the specific geography for this community that served as a guide for data collection and analysis for this CHNA. Table 2 lists zip codes and associated neighborhoods that comprise the community definition.

Figure 9: CCRH Fairhill Community Definition

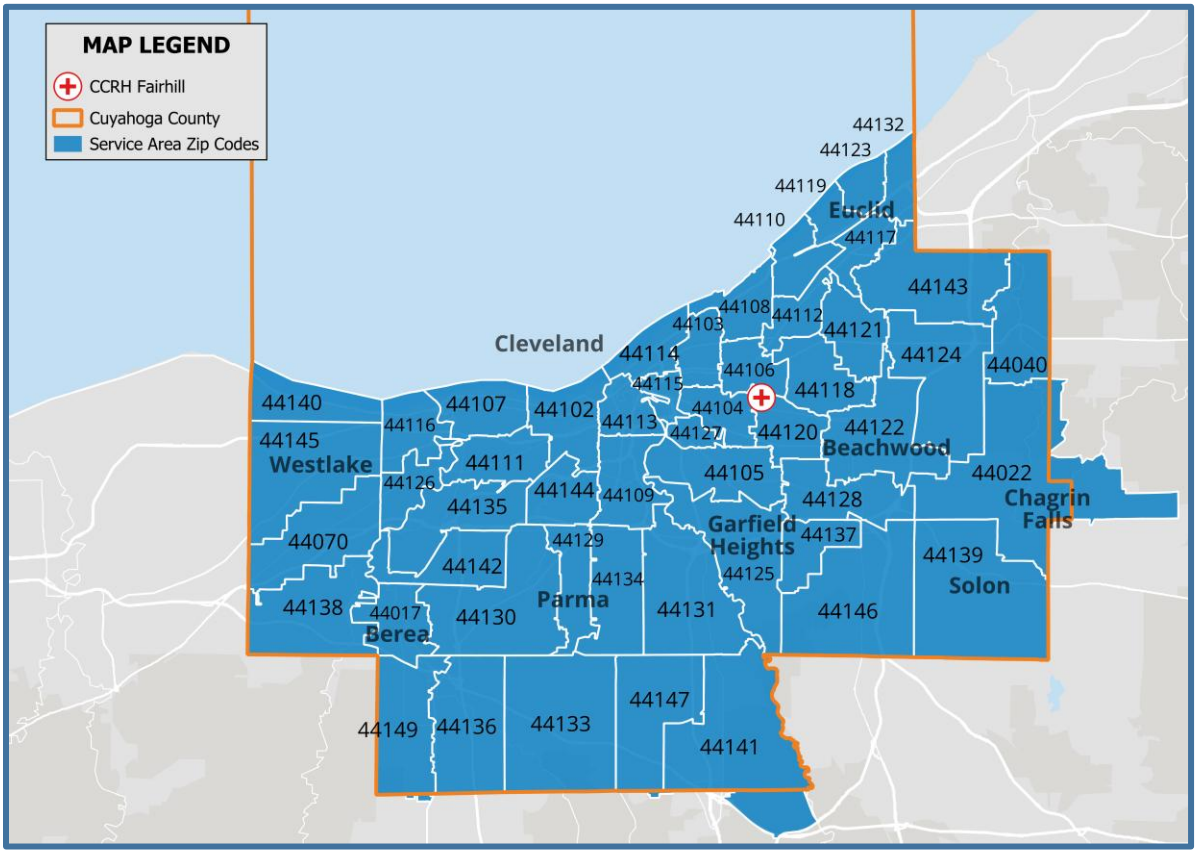


Table 2: CCRH Fairhill Community Definition

Zip Code	Municipality	Zip Code	Municipality
44011	Avon	44118	Cleveland
44022	Chagrin Falls	44129	Cleveland
44039	North Ridgeville	44130	Cleveland
44040	Gates Mills	44092	Wickliffe
44060	Mentor	44107	Lakewood
44070	North Olmsted	44142	Brookpark
44092	Wickliffe	44070	North Olmsted
44094	Willoughby	44039	North Ridgeville
44095	Eastlake	44095	Eastlake
44102	Cleveland (Detroit-Shoreway)	44122	Beachwood
44103	Cleveland (Hough)	44143	Cleveland
44104	Cleveland (Kinsman)	44094	Willoughby
44105	Cleveland (South Broadway)	44124	Cleveland
44106	Cleveland (University)	44060	Mentor
44107	Lakewood	44011	Avon
44108	Cleveland (Forest Hills)	44022	Chagrin Falls
44109	Cleveland (Brooklyn-Centre)	44136	Strongsville
44110	Cleveland (South Collinwood)	44131	Independence
44111	Cleveland (Jefferson)	44139	Solon
44112	Cleveland	44040	Gate Mills
44113	Cleveland (Tremont)		
44115	Cleveland (Industrial Valley)		
44117	Euclid		
44118	Cleveland		

Appendix B: Secondary Data Methodology and Secondary Data

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 CCRH Fairhill Community Health Needs Assessment:

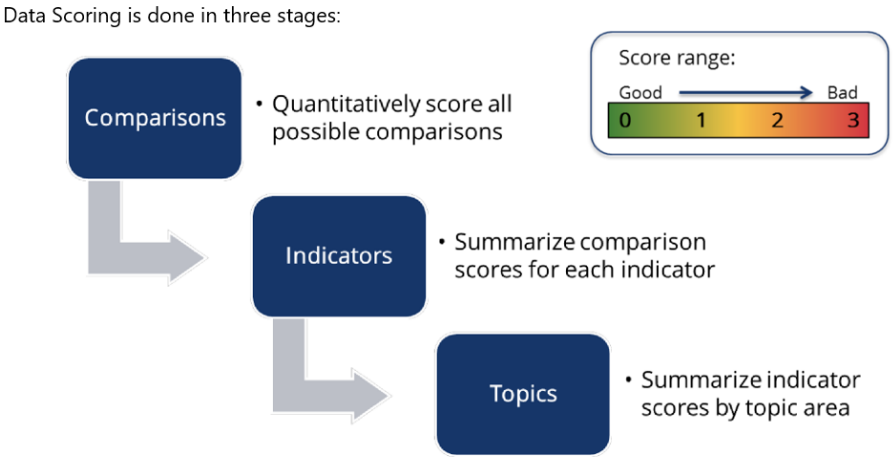
- American Community Survey
- American Lung Association
- Annie E. Casey Foundation
- CDC - PLACES
- Centers for Disease Control and Prevention
- Centers for Medicare & Medicaid Services
- Claritas Consumer Profiles
- Claritas Consumer Spending Dynamix
- County Health Rankings
- Early Ages Healthy Stages
- Feeding America
- National Cancer Institute
- National Center for Education Statistics
- National Environmental Public Health Tracking Network
- Ohio Department of Education
- Ohio Department of Health, Infectious Diseases
- Ohio Department of Health, Vital Statistics
- Ohio Department of Health's Ohio Healthy Homes Lead Poisoning Prevention Program
- Ohio Department of Public Safety, Office of Criminal Justice Services
- Ohio Public Health Information Warehouse
- Ohio Secretary of State
- 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 CCRH Fairhill community, this analysis was completed for Cuyahoga County. A complete breakdown of topic and indicator scores can be found below.

Comparison to a Distribution of County Values: State and Nation

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

Counties with the most concerning scores are “in the red” and those with the least concerning scores are “in the green.”

Comparison to Values: State, National, and Targets

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

Trend Over Time

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

Missing Values

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

Indicator Scoring

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

Topic Scoring

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

Figure 11: Health and Quality of Life Topic Areas



Topics that received a score of 1.50 or higher were considered a significant health need. Eight topics scored at or above this threshold in Cuyahoga County (see Table 2). The highest scoring health topic was *Sexually Transmitted Infections* with a score of 2.04.

Topic Scores

Results from the secondary data topic scoring can be seen in Tables 3 and 4 below. The highest scoring health need in Cuyahoga County was *Sexually Transmitted Infections* with a score of 2.04.

Table 3: Health Topic Scores: Cuyahoga County

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

Table 4: Quality of Life Topic Scores: Cuyahoga County

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

Conduent's SocioNeeds Index Suite®

Conduent HCI's SocioNeeds Index Suite® provides analytics around non-medical drivers of health to better understand how health outcomes differ by geography and identify areas for action. The suite includes the Community Health Index, Food Insecurity Index, and Mental Health Index. See Table 5 for a full list of index values for each zip code in the CCRH Fairhill community.

Table 5: Community Health Index, Food Insecurity Index, and Mental Health Index Values for CCRH Fairhill Community Zip Codes

Zip Code	CHI Value	FII Value	MHI Value	Zip Code	CHI Value	FII Value	MHI Value
44017	43.3	50.0	72.1	**44124**	14.7	29.0	77.7
44022	6.8	14.5	66.4	**44125**	72.3	91.2	94.8
44040	4.9	0.3	25.7	**44126**	33.8	42.7	66.6
44070	38.2	40.6	62.9	**44127**	99.1	98.4	98.3
44102	95.9	96.4	98.5	**44128**	86.9	97.2	99.7
44103	98.4	98.6	99.9	**44129**	46.1	55.7	80.8
44104	99.8	100	100	**44130**	50.5	54.0	82.6
44105	96.5	97.7	99.7	**44131**	23.6	13.2	42.0
44106	83.7	82.6	97.6	**44132**	66.2	95.6	97.1
44107	41.2	49.4	77.2	**44133**	13.1	33.5	58.5
44108	96.6	98.0	99.9	**44134**	58.6	52.0	86.1
44109	94.5	93.8	97.9	**44135**	90.7	92.0	97.4
44110	95.0	99.0	99.7	**44136**	20.0	14.4	59.4
44111	86.9	90.5	94.6	**44137**	72.9	91.2	97.4
44112	93.9	97.0	99.9	**44138**	12.7	5.4	50.9
44113	82.0	84.1	91.7	**44139**	4.7	12.4	34.5
44114	91.2	62.1	96.3	**44140**	8.5	10.2	19.4
44115	99.9	99.9	99.6	**44141**	28.2	2.9	40.5
44116	7.8	12.9	55.2	**44142**	72.6	48.3	84.7
44117	23.4	89.1	99.5	**44143**	19.6	33.0	93.7
44118	31.9	62.9	88.6	**44144**	77.3	83.6	93.2
44119	78.8	92.5	97.2	**44145**	14.8	15.8	64.4
44120	57.1	87.9	98.7	**44146**	25.3	71.7	97.2
44121	22.1	79.4	90.9	**44147**	3.6	19.6	25.5
44122	13.3	35.0	90.6	**44149**	13.8	10.0	35.8
44123	55.6	91.9	97.1				

Figure 12: Census Tract Key, Cuyahoga County (Cleveland East)

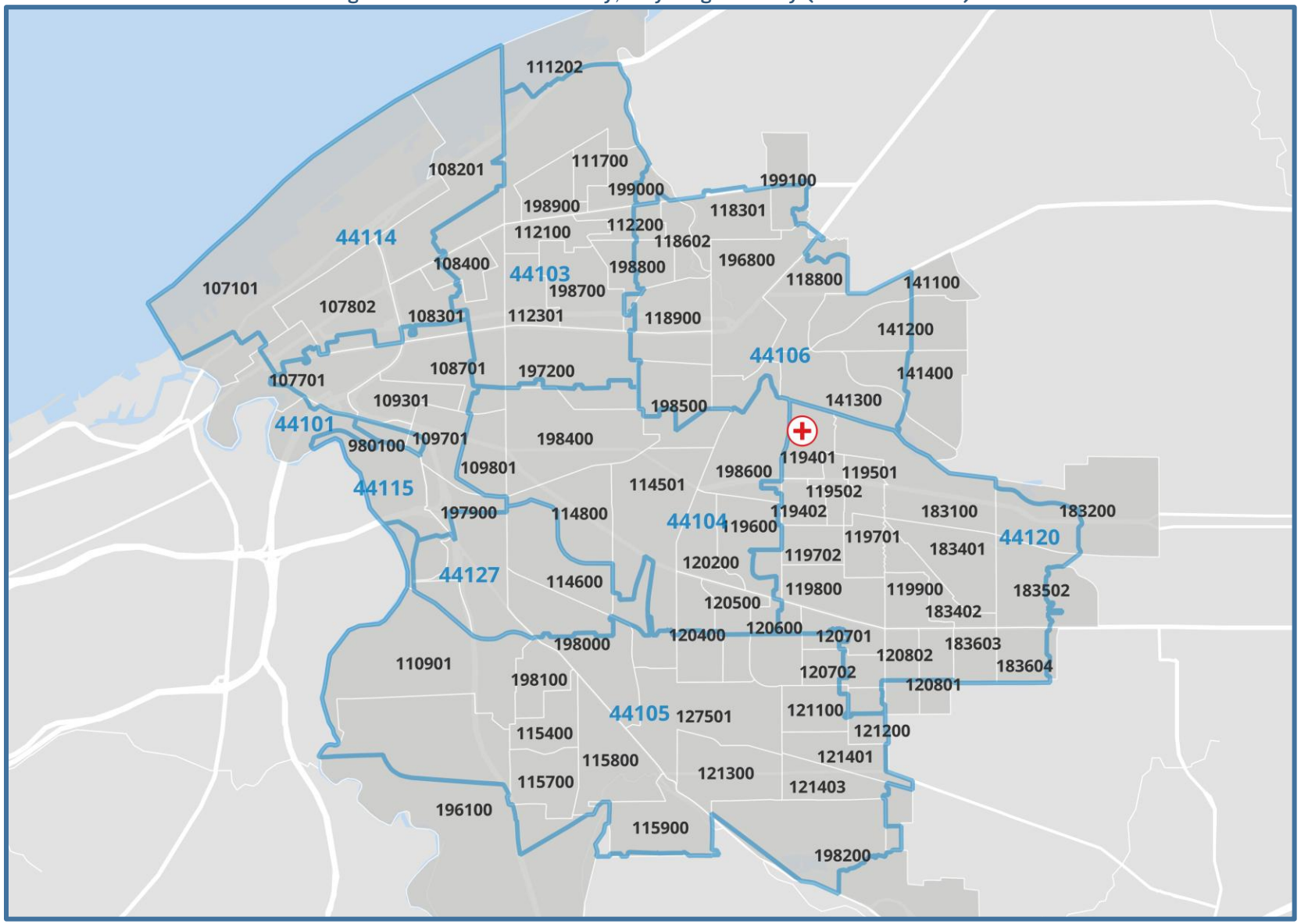


Table 6: Census Tracts by Zip Code, Cuyahoga County (Cleveland East)

44101	44103	44104	44105	44106	44114	44115	44120	44127
109701	101101	108701	110901	112200	105100	107701	119401	114501
980100	101102	109701	114501	118101	106100	107802	119402	114600
	101201	109801	115400	118200	106200	108301	119501	197900
	101300	114501	115700	118301	106500	108701	119502	198000
	101400	114600	115800	118602	137101	109301	119600	980100
	101501	114800	115900	118800	137102	109701	119701	
	101603	119401	120400	118900	137103	109801	119702	
	101700	119600	120500	141000	197400	132302	119800	
	101800	120200	120600	141100		197900	119900	
	101901	120400	120701	141200		980100	120600	
	102200	120500	120702	141300			120701	
	102300	120600	121100	141400			120702	
	102401	197200	121200	151700			120801	
	102402	198400	121300	196800			120802	
	102700	198500	121401	197200			121100	
	102800	198600	121403	198400			121200	
	103500		127501	198500			121700	
	103602		154200	198600			183100	
	105100		154400	198800			183200	
	105300		196100	199000			183401	
	137101		198000	199100			183402	
	177403		198100				183502	
	197500		198200				183603	
	980200		980100				183604	
							183605	
							198600	

Figure 13: Census Tract Key, Cuyahoga County (Cleveland West)

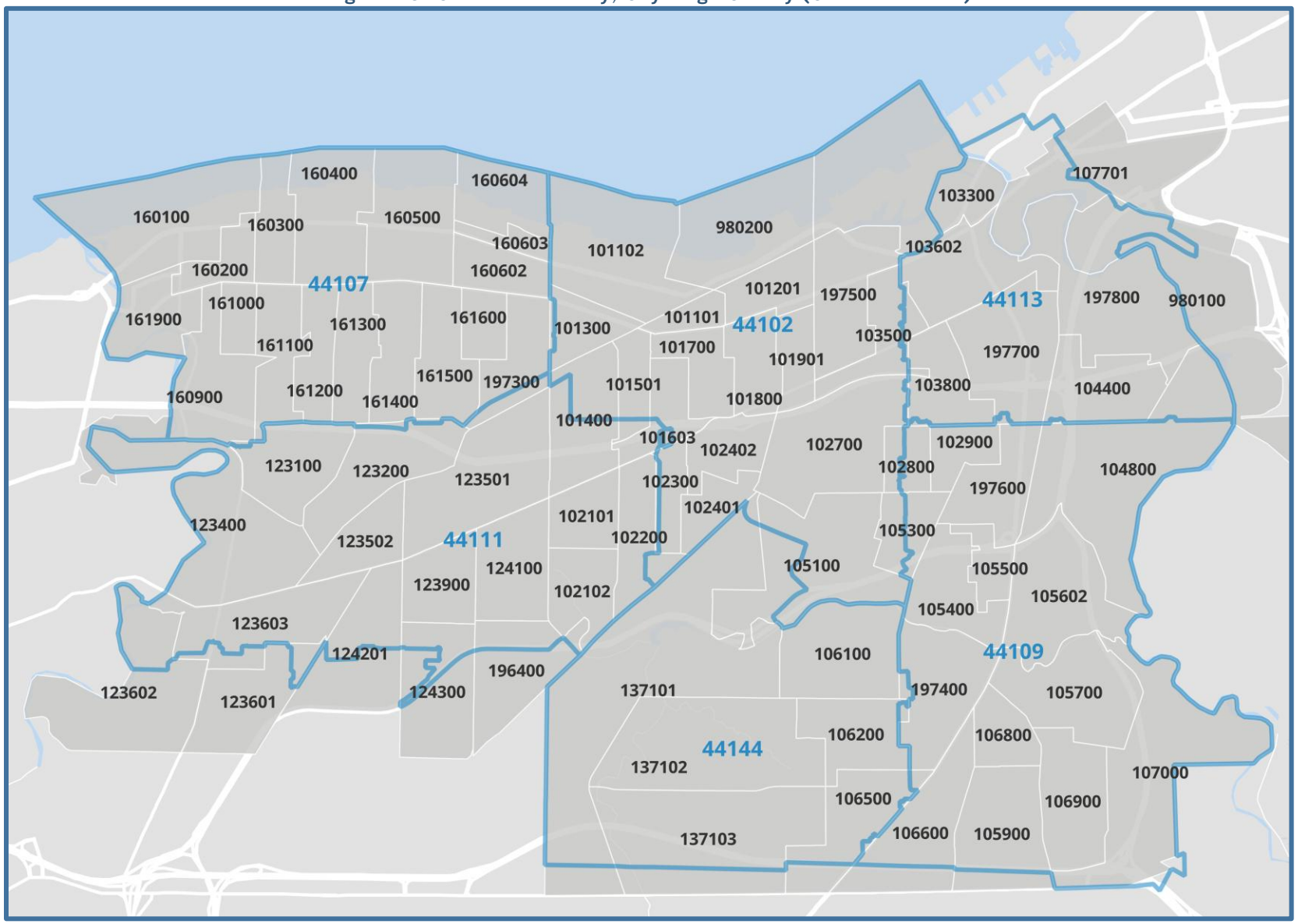


Table 7: Census Tracts by Zip Code, Cuyahoga County (Cleveland West)

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 14: Census Tract Key, Cuyahoga County (North)

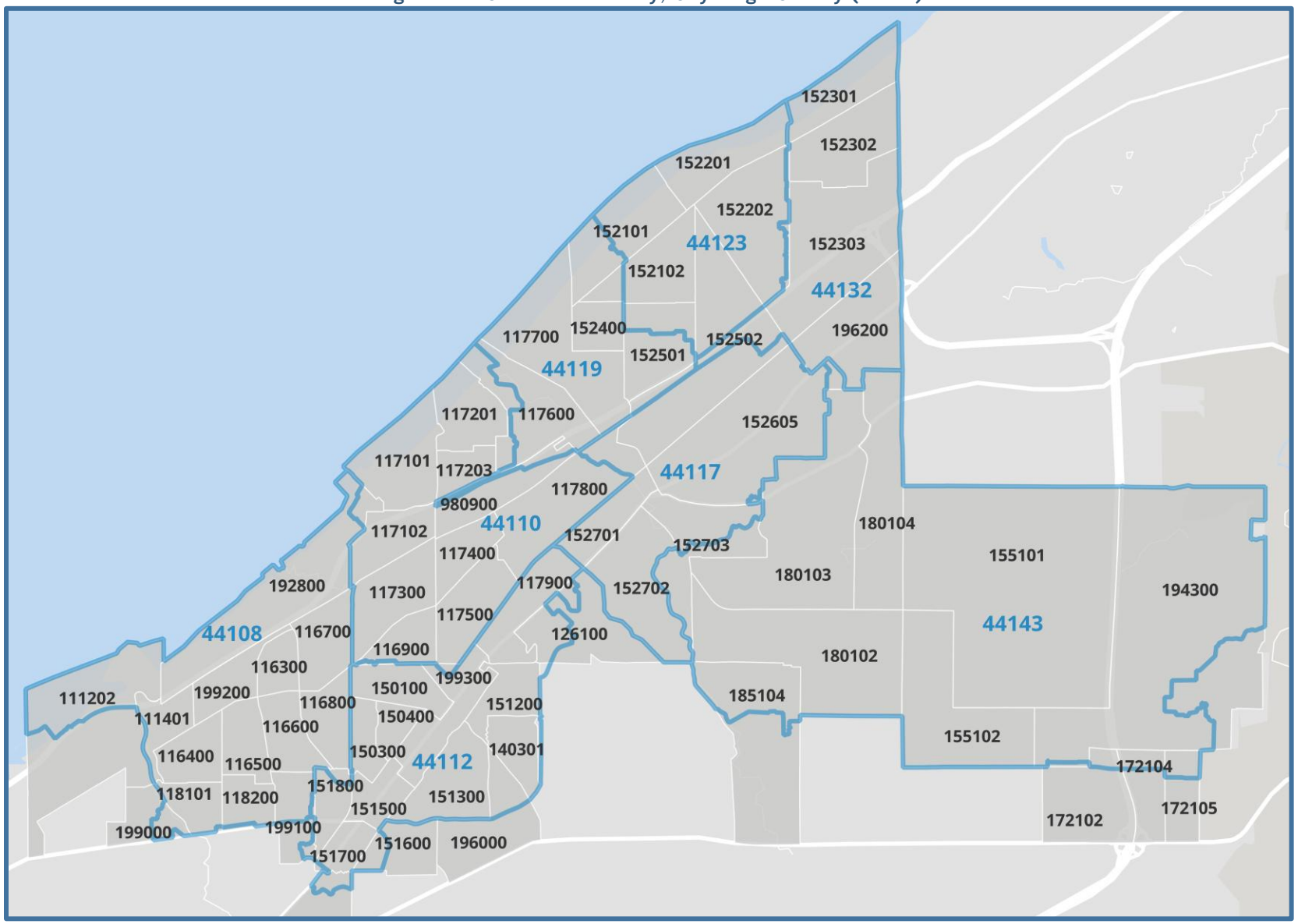


Table 8: Census Tracts by Zip Code, Cuyahoga County (North)

44106	44108	44110	44112	44117	44118	44121	44123
111202	116900	116900	117800	152101	152101	152202	152605
111401	117101	117900	152502	152102	152102	152301	152703
116300	117102	118800	152605	152400	152201	152302	155101
116400	117201	126100	152701	152501	152202	152303	155102
116500	117203	140100	152702	152502	152301	152502	172102
116600	117300	140301	152703	117600	152303	152605	172104
116700	117400	140302	180103	117700	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 15: Census Tract Key, Cuyahoga County (East)

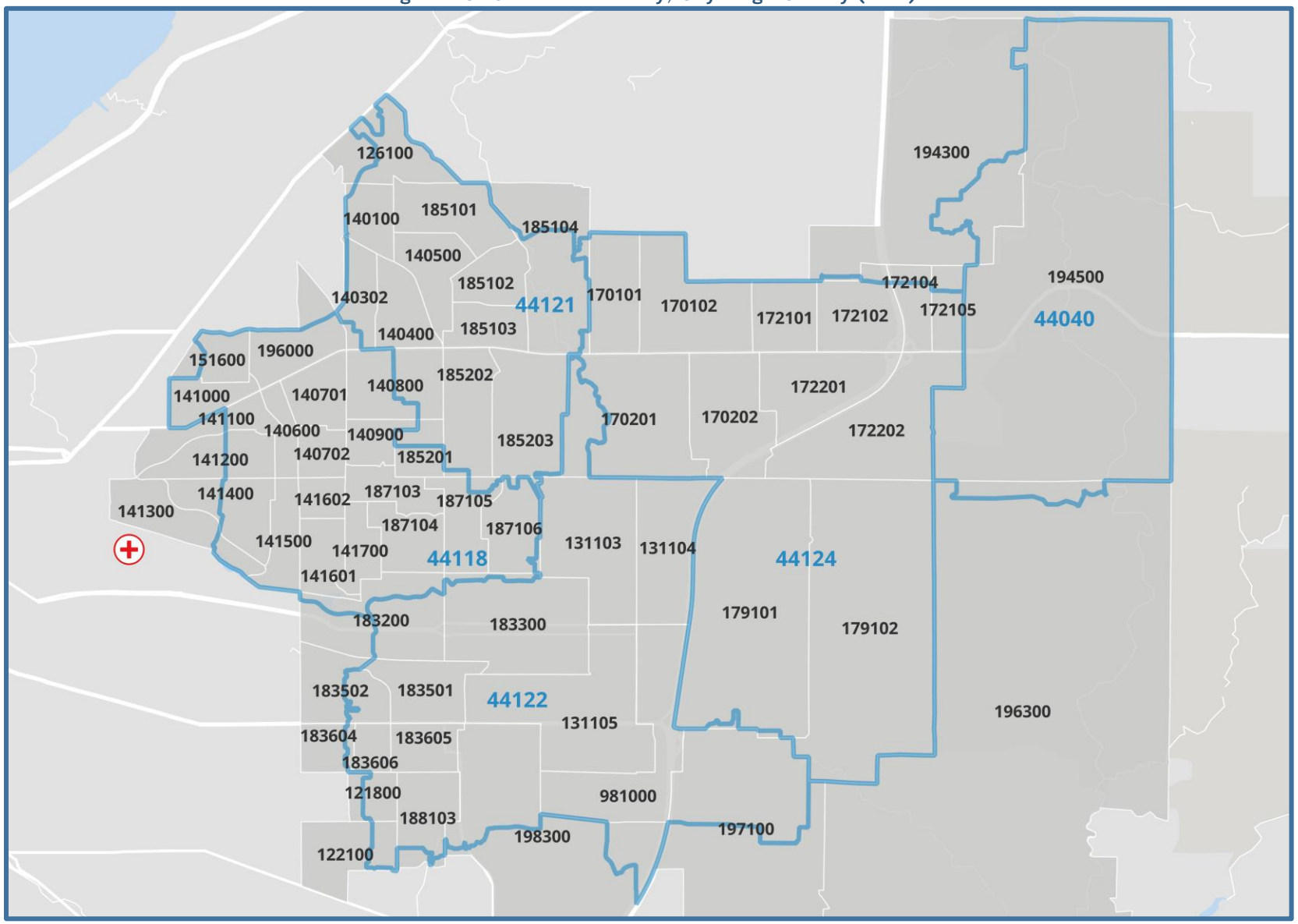


Table 9: Census Tracts by Zip Code, Cuyahoga County (East)

44121	44123	44124	44143
194300	140302	117900	121800
194500	140600	126100	122100
196300	140701	140100	131103
310600	140702	140301	131104
	140800	140302	131105
	140900	140400	170201
	141000	140500	179101
	141100	140800	183200
	141200	151200	183300
	141300	170201	183501
	141400	185101	183502
	141500	185102	183604
	141601	185103	183605
	141602	185104	183606
	141700	185201	185203
	151300	185202	187106
	151600	185203	188103
	183200	187105	197100
	183300	187106	198300
	185201		981000
	185202		
	187103		
	187104		
	187105		
	187106		
	196000		

Figure 16: Census Tract Key, Cuyahoga County (Southeast)

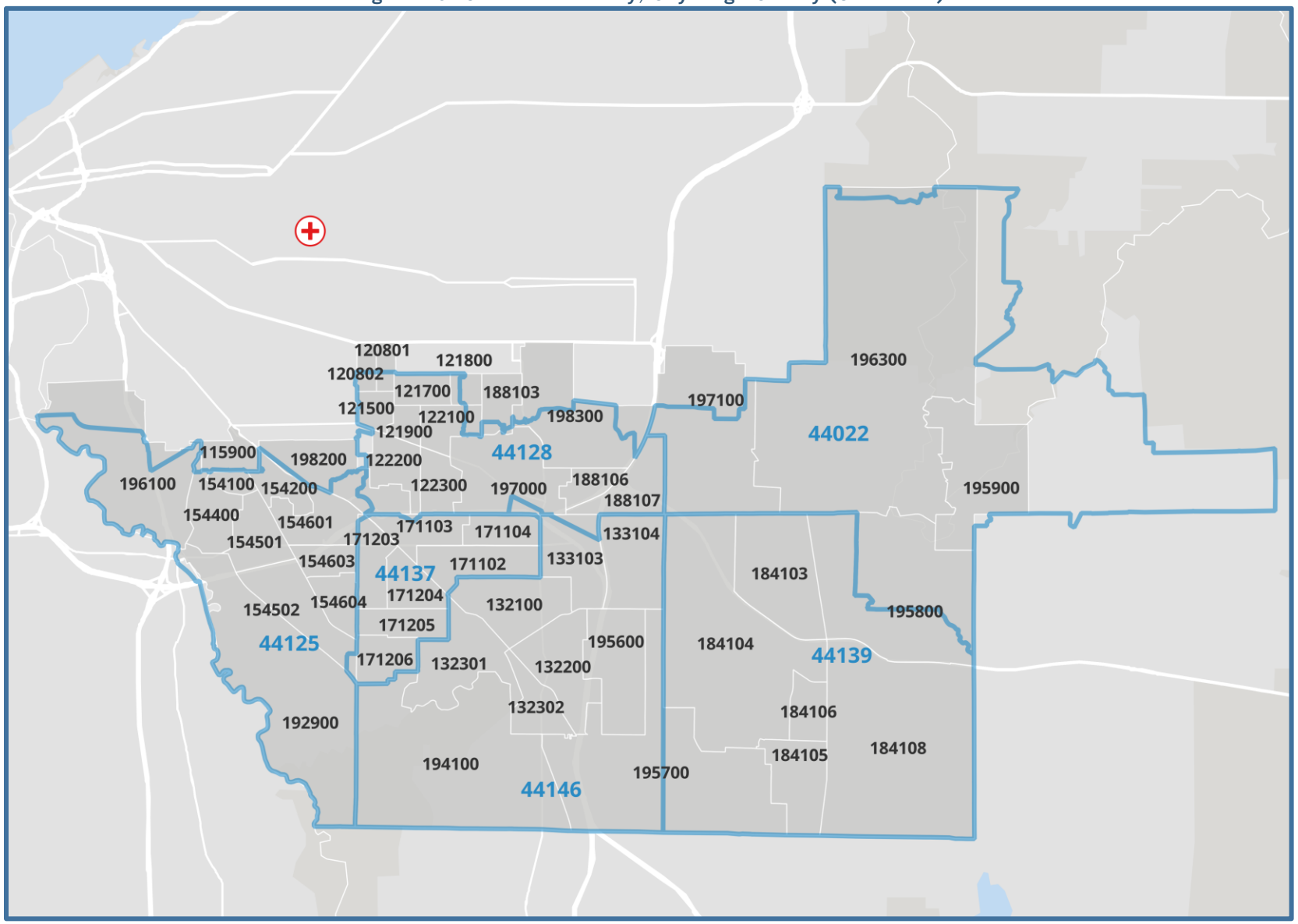


Table 10: Census Tracts by Zip Code, Cuyahoga County (Southeast)

44106	44108	44110	44112	44117	44118
179102	115900	120702	132100	184103	132100
195800	154100	120801	132302	184104	132200
195900	154200	120802	154502	184105	132301
196300	154400	121200	154604	184106	133103
197100	154501	121401	171102	184108	133104
310600	154502	121403	171103	195700	141206
311500	154601	121500	171104	195800	171206
311600	154603	121700	171203		194100
311700	154604	121800	171204		195600
	156101	121900	171205		195700
	171103	122100	171206		197000
	171203	122200			
	192900	122300			
	194100	133103			
	196100	133104			
	198200	171103			
		183603			
		183604			
		188103			
		188106			
		188107			
		197000			
		197100			
		198200			
		198300			

Figure 17: Census Tract Key, Cuyahoga County (South)

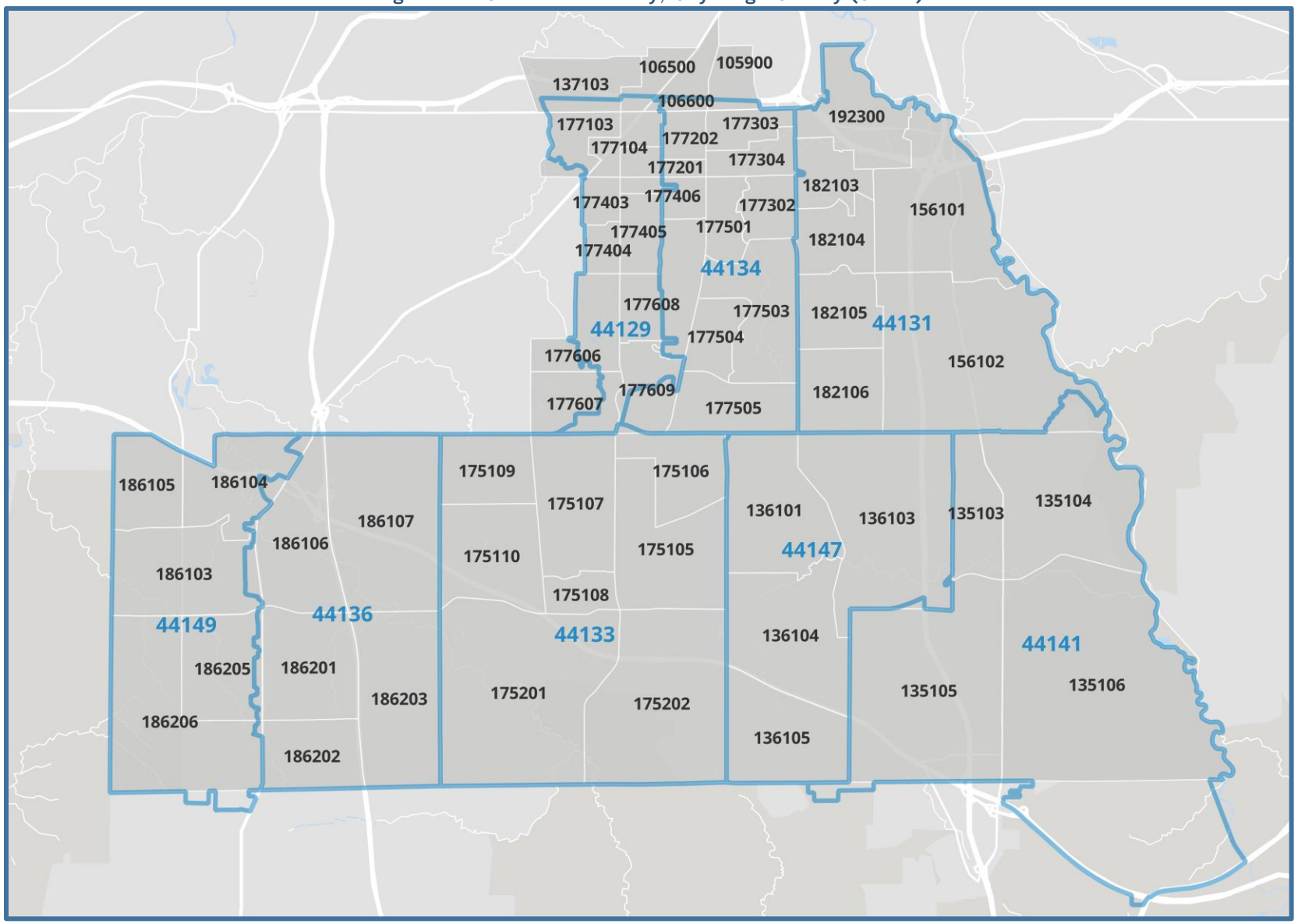


Table 11: Census Tracts by Zip Code, Cuyahoga County (South)

44106	44108	44110	44112	44117	44118	44121	44123
106500	107000	175105	105900	186103	135103	136101	186103
106600	136103	175106	106600	186104	135104	136103	186104
137103	156101	175107	177201	186106	135105	136104	186105
177103	156102	175108	177202	186107	135106	136105	186205
177104	182103	175109	177302	186201			186206
177201	182104	175110	177303	186202			
177202	182105	175201	177304	186203			
177403	182106	175202	177406	186205			
177404	192300		177501	186206			
177405	192900		177503	415100			
177406			177504				
177606			177505				
177607			177608				
177608							
177609							
178201							
178204							

Figure 18: Census Tract Key, Cuyahoga County (West)

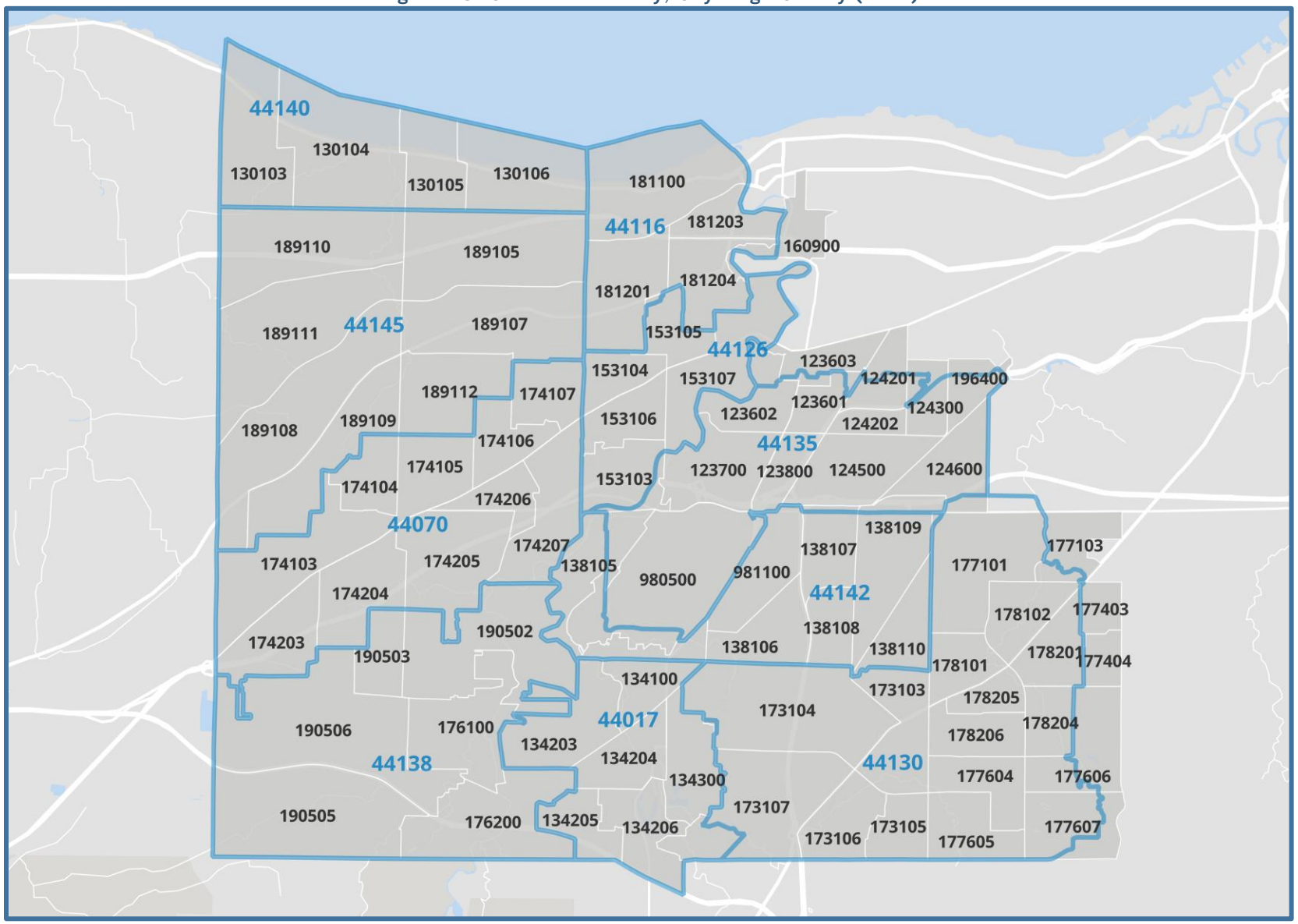


Table 12: Census Tracts by Zip Code, Cuyahoga County (West)

44106	44108	44110	44112	44117	44118	44121	44123	44124	44143
134100	174103	153105	153103	124600	123601	176100	130103	138105	189105
134203	174104	160900	153104	137101	123602	176200	130104	138106	189107
134204	174105	181100	153105	137103	123603	190502	130105	138107	189108
134205	174106	181201	153106	173103	123700	190503	130106	138108	189109
134206	174107	181203	153107	173104	123800	190505		138109	189110
134300	174203	181204		173105	124201	190506		138110	189111
173107	174204			173106	124202			177101	189112
	174205			173107	124300			980500	
	174206			177101	124500			981100	
	174207			177103	124600				
	189112			177403	138107				
				177404	138109				
				177604	153103				
				177605	196400				
				177606	980500				
				177607	981100				
				178101					
				178102					
				178201					
				178204					
				178205					
				178206					

Community Health Index (CHI)

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

HOW IS THE INDEX VALUE CALCULATED?

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

WHAT DO THE RANKS AND COLORS MEAN?

Ranks and colors help to identify the relative level of need within a community or service area. The national index value for each location is compared to all other similar locations within the community area to assign a relative rank (from 1 to 5) locally. These ranks are used to color the map and chart for the CHI, with darker 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 socioeconomic need that is much greater for some subpopulations. Moreover, many of the secondary data indicators included in the findings are collected by survey, and though specific methods are used to represent the population at large, these measures are subject to instability, especially for smaller populations.

Race or Ethnic and Special Population Groupings

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

Zip Codes and Zip Code Tabulation Areas

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

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

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 13 describes how to interpret the icons used to describe county distributions and trend data.

Table 13: Icon Legend

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

Indicators of Concern: Access to Healthcare

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

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

Indicators of Concern: Behavioral Health

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

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

Indicators of Concern: Chronic Disease Prevention and Management

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

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

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

Indicators of Concern: Maternal and Child Health

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

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

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

Indicators of Concern: Health-Related Social Needs

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

SCORE	INDICATOR	UNITS	CUYAHOGA COUNTY	HP2030	OH	U.S.	OH Counties	U.S. Counties	Trend
3.00	People 65+ Living Alone	*percent*	36.1	--	30.2	26.5			
2.82	Median Monthly Owner Costs for Households without a Mortgage	*dollars*	654	--	570	612			
2.82	People 65+ Living Below Poverty Level	*percent*	12.3	--	9.5	10.4			
2.71	Child Food Insecurity Rate	*percent*	26.7	--	19.8	18.5			
2.56	Day Care Center and Preschool Spending-to-Income Ratio	*percent*	8.7	--	7.5	7.4			--

2.56	College Tuition Spending-to-Income Ratio	*percent*	14.7	--	12.9	12.4			--
2.56	Homeowner Spending-to-Income Ratio	*percent*	16.7	--	14.6	14.0			--
2.53	Veterans Living Below Poverty Level	*percent*	9.7	--	7.4	7.2			
2.44	Age-Adjusted Death Rate due to Firearms	*deaths/ 100,000 population*	20.2	10.7	13.5	12.0			--
2.44	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	42.5	--	32.1	--			
2.41	Children in Single-Parent Households	*percent*	37.3	--	26.1	24.8			
2.41	Youth not in School or Working	*percent*	2.7	--	1.7	1.7			
2.38	Adult Day Care Spending-to-Income Ratio	*percent*	13.4	--	11.3	12.3			--
2.38	Home Renter Spending-to-Income Ratio	*percent*	19.3	--	16.8	17.7			--
2.38	Student Loan Spending-to-Income Ratio	*percent*	5.5	--	4.8	4.7			--
2.35	Adults with Internet Access	*percent*	78.6	--	80.9	81.3			
2.26	Residential Segregation - Black/White	*Score*	71.5	--	69.6	--			
2.26	Social Associations	*membership associations/ 10,000 population*	8.9	--	10.8	--			
2.26	People 65+ Living Below 200% of Poverty Level	*percent*	31.9	--	28.4	28.1	--		

2.21	Adults Who Vote in Presidential Elections: Always or Sometimes	*percent*	83.4	--	84.9	85.1			--
2.21	Age-Adjusted Death Rate due to Homicide	*deaths/ 100,000 population*	20.7	5.5	9.0	--	--	--	
2.21	Home Child Care Spending-to-Income Ratio	*percent*	3.8	--	3.3	3.4			--
2.21	Income Inequality	*Gini Index*	0.504	--	0.467	0.483			
2.21	Vocational, Technical, and Other School Tuition Spending-to-Income Ratio	*percent*	1.8	--	1.6	1.6			--
2.21	Student-to-Teacher Ratio	*students/ teacher*	16.9	--	16.6	15.2			
2.18	Linguistic Isolation	*percent*	2.7	--	1.5	4.2			
2.18	Food Insecurity Rate	*percent*	15.1	--	14.1	13.5			
2.12	Median Household Gross Rent	*dollars*	1,005	--	988	1,348			
2.12	Mortgaged Owners Median Monthly Household Costs	*dollars*	1,529	--	1,472	1,902			
2.12	Adults with Disability Living in Poverty	*percent*	33.1	--	28.2	24.6			
2.12	Households that Used Check Cashing, Cash Advance, or Title Loan Shops	*percent*	2.3	--	2.0	2.0			
2.03	Households Living Below Poverty Level	*percent*	16.7	--	14.0	--		--	

2.03	Utilities Spending-to-Income Ratio	*percent*	6.7	--	6.2	5.8			--
2.00	Voter Turnout: Presidential Election	*percent*	65.7	58.4	71.7	--		--	
2.00	Renters Spending 30% or More of Household Income on Rent	*percent*	47.5	25.5	45.1	50.4			

All Indicator Scores by Topic Area

Below is a complete list of all indicators that were scored as part of the secondary data analysis. Indicators are grouped under their respective health and quality of life topic areas and include information about both the indicator data source and measurement period. Please refer to Table 14 below as a reference key for indicator data sources.

Table 14: Indicator Scoring Data Source Key

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

28	U.S. Census Bureau - Small Area Health Insurance Estimates
29	U.S. Environmental Protection Agency
30	United For ALICE

Table 15: All Cuyahoga County Secondary Data Indicators

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

1.35	High School Students who Did Not Go to School Because They Felt Unsafe at School or on Their Way To or From School	*percent*	9.1	*2023*	23
1.35	High School Students who Did Something to Purposefully Hurt Themselves Without Wanting to Die	*percent*	16.3	*2023*	23
1.35	High School Students who Drove After Drinking Alcohol	*percent*	3.2	*2023*	23
1.35	High School Students who Engage in Regular Physical Activity	*percent*	42.8	*2023*	23
1.35	High School Students who Ever Misused Prescription Pain Medication	*percent*	9.5	*2023*	23
1.35	High School Students who Feel Like They Matter to People in Their Community	*percent*	48.4	*2023*	23
1.35	High School Students who had a Check-up or Physical Exam	*percent*	73.4	*2023*	23
1.35	High School Students who had Been Stopped, Questioned, or Searched by Police	*percent*	15.3	*2021*	23
1.35	High School Students who had Mostly Negative or Negative Encounters With Police	*percent*	20.4	*2021*	23
1.35	High School Students Who Have Attempted Suicide: Past Year	*percent*	7.6	*2023*	23
1.35	High School Students who Obtained 8+ Hours of Sleep	*percent*	23.5	*2023*	23

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Additional Demographic Data

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

Table 16: Population Size of CCRH Fairhill Community

Zip Code	Population	Zip Code	Population
44017	17,872	44124	39,419
44022	17,009	44125	28,805
44040	2,857	44126	16,603
44070	31,764	44127	3,857
44102	41,880	44128	26,872
44103	13,419	44129	27,801
44104	19,808	44130	49,467
44105	32,344	44131	20,272
44106	25,926	44132	14,346
44107	49,191	44133	30,594
44108	18,700	44134	37,610
44109	37,444	44135	25,792
44110	17,069	44136	25,526
44111	39,791	44137	23,002
44112	17,532	44138	22,582
44113	21,091	44139	24,698
44114	7,489	44140	15,561
44115	10,323	44141	13,893
44116	21,278	44142	18,043
44117	10,534	44143	24,149
44118	39,323	44144	20,879
44119	11,541	44145	33,573
44120	33,198	44146	29,305
44121	31,296	44147	19,304
44122	36,554	44149	20,003
44123	17,271		
Cuyahoga County	1,228,231		

Table 17: Age Profile of Cuyahoga County and Ohio

Age Category	Cuyahoga County	Ohio
0-4	5.2%	5.6%
5-9	5.4%	5.7%
10-14	5.6%	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	11.2%	11.7%
55-64	13.2%	13.0%
65-74	12.1%	11.6%
75-84	6.2%	6.1%
85+	2.6%	2.2%
Median Age	41.4 years	40.5 years

Table 18: Racial/Ethnic Profile of Cuyahoga County and Surrounding Geographies

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

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

Table 19: Population Age 5+ by Language Spoken at Home, Cuyahoga County and Surrounding Geographies

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

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

Table 20: Household Income of Cuyahoga County and Ohio

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

Table 21: Families Living Below Federal Poverty Level, CCRH Fairhill and Surrounding Geographies

Zip Code	Families Below Poverty	Zip Code	Families Below Poverty
44017	5.9%	44124	3.5%
44022	2.7%	44125	15.2%
44040	3.4%	44126	6.3%
44070	7.0%	44127	32.6%
44102	25.7%	44128	21.9%
44103	32.5%	44129	7.7%
44104	48.8%	44130	7.4%
44105	26.1%	44131	3.0%
44106	19.3%	44132	20.6%
44107	8.4%	44133	2.5%
44108	27.5%	44134	6.1%
44109	21.0%	44135	19.6%
44110	28.7%	44136	3.0%
44111	16.8%	44137	20.1%
44112	24.1%	44138	1.9%
44113	20.3%	44139	3.2%
44114	18.2%	44140	2.6%
44115	58.5%	44141	2.6%
44116	2.9%	44142	6.5%
44117	7.4%	44143	4.1%
44118	9.6%	44144	11.5%
44119	18.2%	44145	4.8%
44120	16.8%	44146	8.3%
44121	12.0%	44147	0.8%
44122	6.1%	44149	2.2%
44123	15.4%		
Cuyahoga County	12.2%		
Ohio	9.4%		
U.S.	8.8%		

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

Table 22: Educational Attainment, CCRH Fairhill and Surrounding Geographies

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

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

Table 23: Renters Spending at Least 30% of Household Income on Rent, CCRH Fairhill 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
44017	41.9%	44124	41.9%
44022	56.2%	44125	61.7%
44040	19.2%	44126	42.0%
44070	44.1%	44127	57.1%
44102	50.1%	44128	49.3%
44103	53.6%	44129	39.0%
44104	51.3%	44130	48.1%
44105	51.8%	44131	31.7%
44106	47.5%	44132	54.4%
44107	37%	44133	32.2%
44108	61.6%	44134	39.7%
44109	50.6%	44135	53.0%
44110	61.6%	44136	41.9%
44111	46.3%	44137	45.4%
44112	64%	44138	29.8%
44113	38.7%	44139	48.7%
44114	48.4%	44140	40.0%
44115	44.6%	44141	35.0%
44116	41.6%	44142	46.2%
44117	62%	44143	47.3%
44118	54.8%	44144	40.7%
44119	53.8%	44145	49.5%
44120	49.6%	44146	51.6%
44121	41.4%	44147	24.2%
44122	42.2%	44149	44.3%
44123	45.7%		
Cuyahoga County	47.5%		
Ohio	45.1%		
U.S.	50.4%		

All values: American Community Survey (2019-2023)

Table 24: Households with an Internet Subscription, CCRH Fairhill and Surrounding Geographies

Zip Code	Households with Internet	Zip Code	Households with Internet
44017	94.3%	44124	92.2%
44022	97.9%	44125	86.7%
44040	97.6%	44126	93.2%
44070	91.3%	44127	70.3%
44102	83.7%	44128	83.4%
44103	73.3%	44129	90.3%
44104	69.3%	44130	89.8%
44105	78.8%	44131	94.3%
44106	84.6%	44132	84.6%
44107	91.6%	44133	93.7%
44108	73.3%	44134	90.3%
44109	85.0%	44135	85.2%
44110	75.5%	44136	92.0%
44111	87.8%	44137	88.0%
44112	72.8%	44138	89.9%
44113	87.5%	44139	95.5%
44114	81.8%	44140	92.0%
44115	74.6%	44141	95.3%
44116	91.1%	44142	87.9%
44117	78.2%	44143	88.9%
44118	92.3%	44144	86.6%
44119	84.6%	44145	93.3%
44120	78.9%	44146	87.1%
44121	90.6%	44147	93.6%
44122	92.8%	44149	91.9%
44123	84.4%		
Cuyahoga County	87.5%		
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 hospital's 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 three prioritized needs in this 2025 CHNA process.

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; Community Safety concerns arising from issues such as poverty, housing insecurity, and gun violence, impact all other areas of health.

- 2023 Ohio State Health Assessment[14]
- 2023 City of Cleveland Parks and Recreation Community Needs Assessment[15]
- 2024 Cuyahoga County ADAMHS Board Needs Assessment[16]
- 2023 Cuyahoga County Planning Commission Data Book[17]
- 2022 Greater Cleveland LGBTQ+ Community Needs Assessment[18]
- Joint 2022 Cuyahoga County CHNA (Collaborating Organizations: University Hospital, Cuyahoga County Board of Health, and the City of Cleveland Department of Health)[19]

[14] Ohio Department of Health. (2023). *Ohio State Health Assessment 2023*. Ohio University; Ohio Department of Health. Retrieved from Ohio Department of Health website.
[15] 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
[16] 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
[17] 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?
[18] 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
[19] 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

- 2023 Livable Cuyahoga Needs Assessment[20]
- 2023 United Way of Greater Cleveland Community Needs Assessment[21]

[20] 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

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

Appendix D: Community Input Assessment Tools and Key Findings

Community Stakeholder Facilitation Guide

Cleveland Clinic

Building a healthy community together.

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 inclusive 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 15 organizations provided feedback for the hospital's 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:

- ADAHMS Board
- ASIA (Asian Services In Action)
- Benjamin Rose Institute on Aging
- Cleveland Department of Public Health
- Cleveland Metropolitan Housing Authority
- Cuyahoga County Board of Health
- Esparanza
- Greater Cleveland Food Bank
- NAMI Greater Cleveland
- LGBTQ+ Assessment Greater Cleveland / Cleveland Clinic
- Neighborhood Family Practice
- City of Cleveland Division of Fire
- Towards Employment
- Positive Education Program
- Lead Safe

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

Access to Healthcare

The following highlights key insights from stakeholder interviews regarding Access to Healthcare in the community. Access to healthcare was consistently identified as a critical issue across stakeholder interviews. While the region has substantial healthcare infrastructure, barriers such as affordability, transportation, provider shortages, and systemic mistrust continue to limit access to services. Participants emphasized that addressing these barriers requires more integrated, community-based approaches that bring services closer to where people live and ensure culturally and linguistically appropriate care.

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

- Affordability remains a significant obstacle, even for those with insurance, with co-pays, prescriptions, and follow-up visits often described as unaffordable.
- Transportation and geographic isolation were repeatedly cited as barriers, particularly for individuals with mobility challenges or those living in outlying neighborhoods.
- Convenience and time play a critical role in healthcare utilization; many residents avoid care when scheduling is complex or requires long wait times.

- Limited representation in the healthcare workforce and lack of services that are culturally aware contribute to mistrust and deter engagement with care.
- Stakeholders called for integrated, co-located services that combine medical, behavioral, and social supports in community-based settings.
- Digital access barriers, including lack of internet, limited literacy, and complicated systems, prevent many residents from navigating healthcare efficiently.

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

"People really need safe environments, safe institutions. They need their basic needs to be met and to have access to the resources they need in order to meet their basic needs."

"Transportation and access to reliable, safe, and warm public transit is one of our community's big challenges. Caregivers are often forced to make difficult choices when trying to access care for themselves or their children."

"When healthcare providers are willing and able to engage community members in a more egalitarian way at the neighborhood clinic level, rather than having to go to the big campus, it creates a sense of connection and belonging."

Overall, stakeholders stressed that healthcare access cannot be achieved through clinical care alone. Affordability, transportation, cultural awareness, and trust are critical to enabling residents to seek preventive and routine care. Building integrated, community-based services that are responsive to local needs was consistently described as essential to ensuring that all residents can access timely, affordable, and culturally appropriate healthcare.

Adult Health

Stakeholders described Adult Health as shaped by a combination of chronic disease burdens, preventive care gaps, and the challenges of aging. Diabetes, hypertension, and obesity were frequently mentioned as persistent concerns. Participants also emphasized that cancer risks, including breast and prostate cancer, remain high in the community. Food insecurity, reliance on fast food, and limited opportunities for physical activity were linked directly to these health outcomes. Older adults were noted as a particularly vulnerable group, with isolation, falls, and the high costs of adult day care making it difficult to maintain health and independence.

The following are highlights of participant feedback regarding prevention and safety:

- High prevalence of chronic diseases such as diabetes, hypertension, and obesity
- Differences in cancer outcomes, especially for breast and prostate cancer
- Food insecurity and dietary habits contributing to poor health outcomes

- Preventive care is underutilized due to barriers such as cost, transportation, and trust
- Older adults are facing isolation, injury risks, and limited affordable support services

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

> *"Families in food deserts struggle to buy affordable healthy food, and this drives up chronic disease."*
>
> *"Diabetes and kidney disease are major problems in our community."*
>
> *"Our older adults are often isolated, and when they live alone it becomes a safety issue, especially with falls and no one there to help."*
>
> *"People avoid preventive visits because of the costs and because they do not trust that it will make a difference if they are not already sick."*

Stakeholder conversations reinforced that Adult Health outcomes are closely tied to both medical and social conditions. Chronic disease, food insecurity, and differences in cancer outcomes highlight the need for culturally relevant prevention, education, and screenings. At the same time, aging-related challenges such as isolation, falls, and financial barriers to care require expanded supports for older adults and investments in community infrastructure. Participants consistently underscored that without coordinated strategies to address these challenges, Adult Health outcomes will continue to lag behind.

Community Safety

Stakeholder conversations emphasized Community Safety as a critical concern affecting health and quality of life. Participants described how violence, crime, and exposure to unsafe environments create daily stress for families and limit opportunities for safe recreation and community connection. Gun violence and overdoses were repeatedly cited as major drivers of fear and instability, particularly in neighborhoods already facing poverty and systemic disinvestment. Alcohol-impaired driving was also mentioned as a recurring challenge. In addition to safety concerns, participants underscored that stigma, limited culturally relevant services, and gaps in harm reduction approaches restrict access to effective prevention and recovery resources.

The following are highlights of participant feedback regarding prevention and safety:

- Housing instability, homelessness, and environmental risks such as lead exposure were identified as significant threats to health and development.
- Neighborhood safety, exposure to violence, and lack of secure recreational spaces negatively impact both mental and physical health.
- Gun violence and crime create fear and chronic stress
- Opioid and fentanyl overdoses remain pressing safety issues
- Alcohol-impaired driving is noted as a significant public health concern

- Unsafe environments limit outdoor activity and community engagement

The following are a selection of quotes illustrating feedback about Prevention and Safety by key informants:

> *"In order to be healthy, a community needs an investment in the people and the places where they live and so investment in the built environment so that there are fewer traffic accidents and less air pollution. Easier access to healthy food. Investment in the people… so that they're not affected by lead poisoning, homelessness, and hypothermia on cold days."*

> *"Our community strengths are the people and the sense of identity and the kind of sense of community here, but those strengths need to be supported with investment in housing, schools, and safe environments."*

> *"Gun violence and overdoses are what we see most, and they create constant fear for families in these neighborhoods."*

> *"People are scared to be outside, and that takes a toll on mental health as much as physical health."*

> *"We need more prevention, not just treatment, so kids have safe spaces and do not fall into the same cycles."*

Stakeholders consistently highlighted that Community Safety is inseparable from public health. Violence, substance use, and unsafe environments compound the effects of poverty and systemic inequities, eroding trust and undermining wellbeing. Respondents stressed the need for comprehensive prevention strategies, expanded recovery resources, and strong community partnerships that engage schools, healthcare systems, and local organizations. By addressing both safety risks and their root causes, communities can create safer, healthier environments that support residents across the lifespan.

Appendix E: Impact Evaluation

CCRH Fairhill does not have a current Impact Evaluation because the facility only recently opened. As a newly established rehabilitation hospital, there was no prior CHNA completed for this site, and therefore no previously identified prioritized health needs, nor measurable initiatives to evaluate at this time. Without a baseline CHNA and associated action plan, it is not possible to conduct a meaningful review of progress or outcomes.

Looking ahead, CCRH Fairhill is committed to ensuring full alignment with CHNA and Implementation Strategy requirements. An Impact Evaluation will be conducted as part of the next CHNA cycle, scheduled in three years. This evaluation will provide a comprehensive review of the strategies implemented following the 2025 CHNA and assess the hospital's measurable impact on community health outcomes over the next cycle.

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 conduent.com/community-population-health.

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25-CCC-6446158

Cleveland Clinic
Rehabilitation Hospital
In affiliation with Select Medical

Fairhill

Implementation Strategy Report

2025

CLEVELAND CLINIC REHABILITATION HOSPITAL FAIRHILL
2025 Community Health Needs Assessment
Implementation Strategy Report for Years 2026 – 2028

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Cleveland Clinic Rehabilitation Hospital Fairhill 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 Rehabilitation Hospital Fairhill (CCRH Fairhill or "the hospital") 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 CCRH Fairhill. This report includes strategies for years 2026 through 2028.

A. Description of Hospital

CCRH Fairhill is a newly constructed 32-bed all-private-room rehabilitation facility located in Cleveland, Ohio. Opened in partnership with Select Medical, this new facility provides specialized care for patients with complex injuries and illnesses. It is located within the existing Select Specialty Hospital. Additional information on the hospital and its services is available at: my.clevelandclinic.org/locations/rehabilitation-hospital.

The hospital is a joint venture between Cleveland Clinic health system and Select Medical. As part of the broader Cleveland Clinic health system, CCRH Fairhill upholds the tripartite mission of clinical care, research, and education. Cleveland Clinic 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 CCRH Fairhill, contributes to the system-wide advancement of clinical research and medical innovation. Patients at CCRH Fairhill benefit from access to novel treatments, clinical trials, and evidence-based practices developed and shared across the Cleveland Clinic network.

Select Medical is one of the largest providers of post-acute care encompassing three areas of expertise: critical illness recovery, inpatient medical rehabilitation, and outpatient physical therapy, all of which are delivered and supported by talented healthcare professionals across the U.S. Additional information about Select Medical is available at selectmedical.com/.

II. CCRH Fairhill Community Definition

The community definition describes the zip codes where approximately 75% of discharges from the hospital are anticipated to originate from for the newly established CCRH Fairhill. 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 neighborhoods that comprise the community definition.

Figure 1: CCRH Fairhill Community Definition

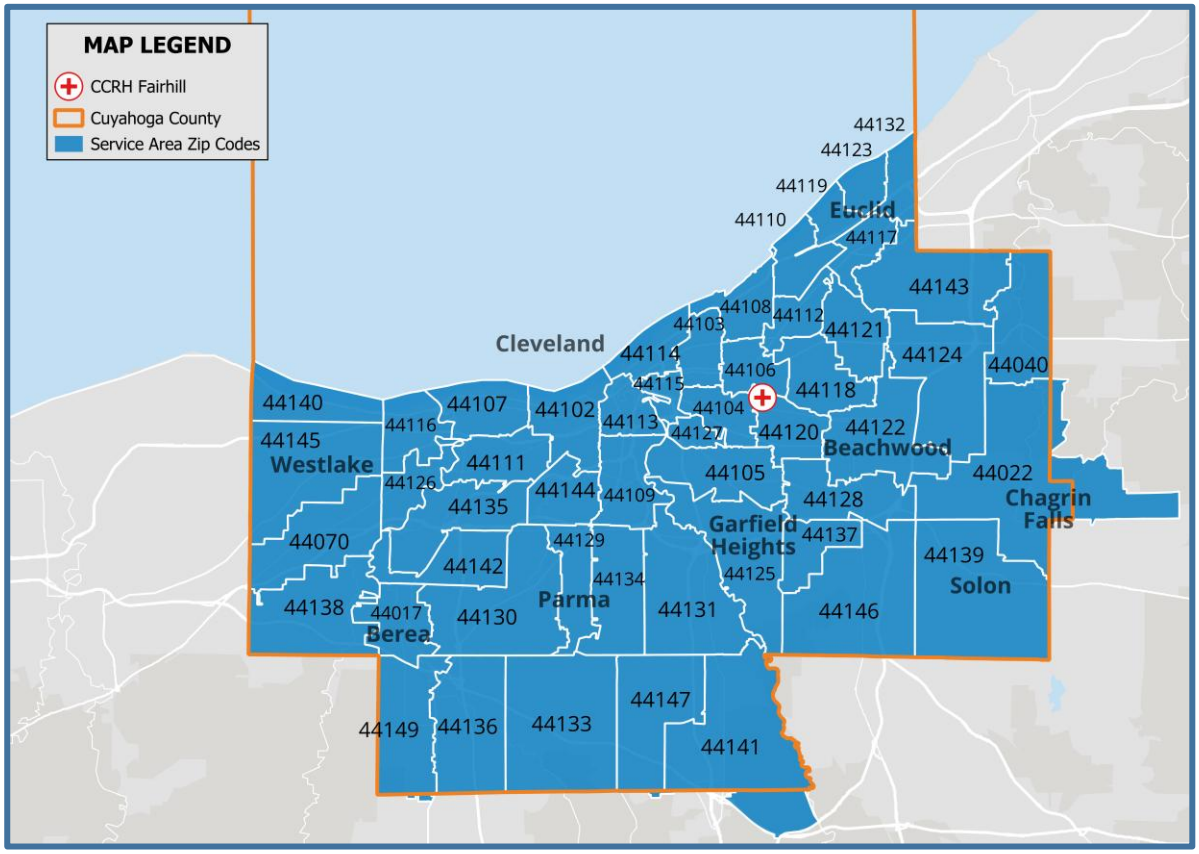


Table 1: CCRH Fairhill Community Definition

Zip Code	Municipality	Zip Code	Municipality
44011	Avon	44118	Cleveland
44022	Chagrin Falls	44129	Cleveland
44039	North Ridgeville	44130	Cleveland
44040	Gates Mills	44092	Wickliffe
44060	Mentor	44107	Lakewood
44070	North Olmsted	44142	Brookpark
44092	Wickliffe	44070	North Olmsted
44094	Willoughby	44039	North Ridgeville
44095	Eastlake	44095	Eastlake
44102	Cleveland (Detroit-Shoreway)	44122	Beachwood
44103	Cleveland (Hough)	44143	Cleveland
44104	Cleveland (Kinsman)	44094	Willoughby
44105	Cleveland (South Broadway)	44124	Cleveland
44106	Cleveland (University)	44060	Mentor
44107	Lakewood	44011	Avon
44108	Cleveland (Forest Hills)	44022	Chagrin Falls
44109	Cleveland (Brooklyn-Centre)	44136	Strongsville
44110	Cleveland (South Collinwood)	44131	Independence
44111	Cleveland (Jefferson)	44139	Solon
44112	Cleveland	44040	Gate Mills
44113	Cleveland (Tremont)		
44115	Cleveland (Industrial Valley)		
44117	Euclid		
44118	Cleveland		

III. How Implementation Strategy was Developed

This Implementation Strategy was developed by members of senior leadership at Fairhill Rehabilitation and Cleveland Clinic representing several departments of these organizations. Leadership at CCRH Fairhill 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

CCRH Fairhill's 2025 Community Health Needs Assessment identifies three core health priorities based on a 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 three prioritized health needs will help shape the hospital's Implementation Strategy Reports (ISR) for the subsequent three years:

- Access to Healthcare
- Adult Health
- Community Safety

It should be noted that no one organization can address all the health needs identified in its community. Fairhill Rehabilitation is committed to serving the community by adhering to its mission and using its skills, expertise, and resources to provide a range of community benefit programs to address post-acute rehabilitation services for adults.

V. Needs Hospital Will Address

Each Cleveland Clinic hospital provides numerous services and programs in efforts to address the health needs of the community. Implementation of our services focuses on addressing structural factors important for community health, strengthening trust with residents and stakeholders, ensuring community voice in developing strategies, and evaluating our strategies and programs. Strategies within the ISRs are included according to the prioritized list of needs developed during the 2025 CHNA. Acknowledging that Fairhill Rehabilitation opened in October 2025, these strategies are exploratory.

- Access to Healthcare
- Adult Health
- Community Safety

A. Access to Healthcare

Access to Healthcare data analysis results describe community needs related to consumer expenditures for insurance, medical expenses, medicines, and other supplies. More expansive parameters include limitations to accessing healthcare described in terms of transportation challenges, resource limitations, and availability of primary care and other prevention services in local neighborhoods.

Access to Healthcare Initiatives for 2026-2028 include:

1. CCRH Fairhill provides medically necessary services to all patients regardless of race, color, creed, gender, country of national origin, or ability to pay. CCRH Fairhill has a financial assistance policy that provides free or discounted care based on financial need. Financial assistance may also be provided to patients on a case-by-case basis under certain medical circumstances. The financial assistance policy can be found here: CCRH Fairhill Financial Assistance
2. The term "rehabilitation" is widely used to describe many different levels of care, which contributes to confusion among stakeholders. The rehabilitation offered at CCRH Fairhill is defined by licensure and regulatory requirements. For patients, confusion surrounding rehabilitation can be a barrier to accessing the right level of care at the right time. CCRH Fairhill will develop and share educational materials with patients, families, and providers to broaden community awareness and improve patients' ability to choose the most appropriate care setting.
3. A key cornerstone of inpatient rehabilitation is the prevention of stroke and brain injury through patient and community education. Clinical staff serving the Brain Injury and Stroke Program teams at CCRH Fairhill will develop support groups and educational sessions for families and community residents. As part of this education and outreach, the hospital will provide information on post-acute care settings, how to access different levels of care, and community based resources.

B. Adult Health

Adult Health encompasses several subtopics where information is available including Older Adult Health; Other Conditions; and Chronic Disease Prevention and Management including Nutrition and Healthy Eating. By addressing these issues in concert, Fairhill Rehabilitation hopes to impact concerns for older adult mental health from isolation, chronic conditions, and access to healthy food.

Adult Health Initiatives for 2026-2028 include:

1. Each patient is followed by a physician's service throughout their stay at the rehabilitation hospital. Physicians educate patients on their overall healthcare and on potential risk factors that may affect their recovery. They also educate patients on their past medical history and how their existing conditions may be impacted by their new injury. There are consulting physicians including but not limited to cardiologists, pulmonologists, and nephrologists that are available for consultation regarding secondary diagnoses or complications related to the new injury/illness. Additionally, through CCRH Fairhill's linkage with Cleveland Clinic, patients have access to comprehensive diagnostic, medical, and surgical services.
2. Provide education and training to patients to increase mobility and activity. Discussions regarding healthy eating and interpretation of food labels may be initiated as part of the therapy care plan.
3. Continuing education is routinely provided to nursing and pharmacy staff specific to diabetes medication and diabetic management.

4. Depression and emotional changes are common following illness or injury. These occur as primary effects of the illness, as in the case of stroke, or as secondary reactions to new disabilities that may have commonly pre-existed the event.
    a. Psychologists are capable of evaluation and psychotherapeutic treatment of a variety of disorders. The attending psychiatrist often will start pharmacological intervention with antidepressant medications, mood stabilizers, and anxiolytics. It is important to use medications that can improve recovery and to avoid and/or discontinue those medications that have been shown or hypothesized to impede recovery.
    b. Therapists and nursing staff also provide emotional support, encouragement, and hope. It is also essential to use non-pharmacological techniques to help with these psychological disorders.
    c. Recreational therapy is essential to help add some "downtime" to the rigors of the therapy schedule as well as to help patients realize and replicate common activities of daily living that will need to be performed after discharge.
5. CCRH Fairhill will leverage relationships with providers across the continuum of post-acute care in order to cross-refer, provide patient education, and support self-advocacy. Recognizing the health literacy needs of the community and the wide array of post-acute care options available, CCRH Fairhill has developed a large network of clinical liaisons throughout the community to assist elderly consumers in understanding their post-acute care options. The hospital offers facility tours and coordinates with our acute care case management partners.

C. Community Safety

Community Safety issues, though related to social drivers, stands apart as a health topic intended to describe community health needs related to the following subtopics: Prevention & Safety and Alcohol & Drug Use.

Community Safety Initiatives for 2026-2028 include:

1. Falls represent a particular concern for our elderly populations. CCRH Fairhill has developed evidence-based falls prevention education for internal and external stakeholders including information on environmental modifications, balance exercises, and home safety assessments. In addition to focusing on falls prevention, the hospital also provides educational materials detailing how to reduce the likelihood of injury should a fall occur.
2. Tobacco use is a risk factor for several medical conditions commonly treated in the inpatient rehabilitation setting. Smoking can also increase the risk of disease recurrence and presents a significant barrier to healthy living. A formalized smoking cessation program will be developed including resources and education that can be provided to patients during an inpatient rehabilitation stay. Patients will also be connected with organizations in the community for ongoing follow up and support. Low-cost or free smoking cessation resources will also be investigated.

3. CCRH Fairhill is committed to preventing deaths from opioid overdose by improving opioid prescribing practices, reducing exposure to opioids, and preventing misuse. The hospital has formalized an internal opioid management process for reviewing healthcare prescribing, data collection, and the use of non-pharmacologic treatment for pain.
    a. Healthcare providers screen all patients for pain on admission and develop a pain management plan based on the patient's input, history, and desired goals.
    b. Appropriate referrals to community programs, such as AA, NA, or mental health resources are delivered by case management and psychology staff.

While this ISR outlines specific strategies and programs identified to address the 2025 CHNA prioritized areas of Access to Healthcare, Adult Health, and Community Safety, it does not reflect all the work being done by CCRH Fairhill 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 CCRH Fairhill 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 .

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23-CCO-3621401