Cleveland Clinic
Fairview Hospital

Community Health Needs Assessment

2025



Table of Contents

Fairview Hospital 2025 Community Health Needs Assessment 3
Introduction 3
Fairview Hospital Community Definition 4
Summary 6
2025 Prioritized Health Needs 6
Prioritized Health Need #1: Access to Healthcare 7
Prioritized Health Need #2: Behavioral Health 9
Prioritized Health Need #3: Chronic Disease Prevention and Management 11
Prioritized Health Need #4: Maternal and Child Health 14
Prioritized Health Need #5: Health-Related Social Needs 16
Prioritized Health Needs in Context 17
Secondary Data Overview 18
Primary Data Overview 30
Prioritization Methodology 32
Collaborating Organizations 32
Community Partners and Resources 32
Comments Received on Previous CHNA 34
Request for Public Comment 34
Appendices Summary 34
Appendix A: Fairview Hospital Community Definition 35
Appendix B: Secondary Data Sources and Analysis 36
Appendix C: Environmental Scan and Key Findings 101
Appendix D: Community Input Assessment Tools and Key Findings 102
Appendix E: Impact Evaluation 113
Appendix F: Acknowledgements 117
Appendix G: City of Lakewood Community Health Needs Assessment 118

Fairview Hospital Implementation Strategy Report 120

Fairview Hospital 2025 Community Health Needs Assessment

Introduction

Fairview Hospital, a member of the Cleveland Clinic health system, is a 498-bed[1] acute-care teaching hospital located at the western edge of Cleveland, overlooking the Cleveland Metroparks. With more than 110 years of service to the community, Fairview Hospital offers a comprehensive range of medical services supported by clinical Centers of Excellence in heart care, cancer, birthing, surgery, emergency, and trauma services. The hospital is accredited by the Joint Commission and serves as a training site for residency programs in family medicine, general surgery, and internal medicine, with affiliations to multiple medical schools for student clerkships. Fairview also participates in advanced specialty training programs sponsored by Cleveland Clinic, including anesthesiology, pediatrics, radiology, and sports medicine. The hospital is nationally recognized for its leadership in blood conservation through its Center for Blood Conservation and serves as the first site for the Bloodless Medicine and Surgery Institute, training clinicians worldwide in innovative approaches to blood management. Fairview Hospital continues to earn recognition for the quality of its care from national accrediting bodies, insurers, referring physicians, and the patients and families it serves.

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

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

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

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

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

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

CHNA Background

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

Fairview Hospital Community Definition

The community definition describes the zip codes where approximately 75% of Fairview Hospital Emergency Department discharges originated in 2023. Figure 1 shows the specific geography for the Fairview Hospital 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: Fairview Hospital Community Definition

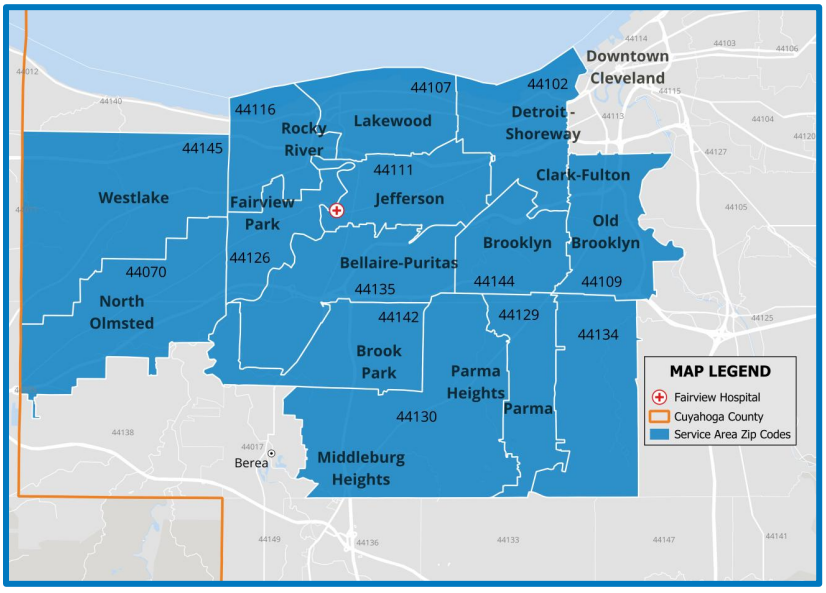


Table 1: Fairview Hospital Community Definition

Zip Code	Postal Name
44070	North Olmsted
44102	Detroit-Shoreway
44107	Lakewood
44109	Brooklyn-Centre
44111	Jefferson
44116	Rocky River
44126	Fairview Park
44129	Parma
44130	Middleburg Heights
44134	Parma
44135	Bellaire-Puritas
44142	Brook Park
44144	Brooklyn
44145	Westlake

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 14-zip-code Fairview Hospital community area. Data were compared to national benchmarks, state averages, and historical trends to identify areas of concern. The analysis reinforced five key health priorities, Access to Healthcare, Behavioral Health, Chronic Disease Prevention and Management, Maternal and Child Health, and Health-Related Social Needs, highlighting differences in outcomes by group.

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

Across communities, consistent themes emerged: cost barriers and provider shortages limit healthcare access; behavioral health treatment gaps remain significant; chronic

disease management is challenged by food insecurity and inadequate recreational infrastructure; differences in maternal and child health outcomes persist among certain communities; and health-related social needs, particularly poverty, housing insecurity, and gun violence, impact all other areas of health.

Primary Data Methodology and Key Findings

To ensure community priorities and lived experience were centered in this assessment, conversations with community stakeholders were conducted across the Fairview Hospital community. Community stakeholders from 19 organizations provided feedback for the Fairview Hospital community. Participants represented sectors including public health, mental health, housing, food access, child and family services, and grassroots organizations. Feedback consistently reinforced the five identified health priorities and revealed community-specific challenges affecting health outcomes, such as long wait times for pediatric care, gaps in behavioral health support, housing-related health risks, and challenges accessing culturally competent prenatal care. Economic hardship was described as a root cause affecting every other health domain. Stakeholders called for expanded prevention, investment in community infrastructure, and systems-level changes that address the underlying conditions shaping health across generations.

Summary

2025 Prioritized Health Needs

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



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

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

Prioritized Health Need #1: Access to Healthcare



Access to Healthcare remains a critical and enduring concern for the Fairview Hospital community, as highlighted through stakeholder interviews conducted for the 2025 CHNA. Stakeholders underscored that despite the presence of healthcare infrastructure in the region, barriers to care continue to impact many communities, including low-income populations, older adults, and communities of color. When care is delayed or avoided due to cost, transportation, technology barriers, or mistrust, health outcomes worsen, and reliance on emergency departments increases. Participants reinforced the essential role of timely, affordable, and culturally appropriate care in supporting prevention, chronic disease management, and overall quality of life.

Stakeholders consistently pointed to affordability as a dominant challenge, even for individuals with insurance. High co-pays, limited prescription coverage, and the financial burden of follow-up appointments often discourage people from seeking necessary care. Transportation also emerged as a repeated concern, particularly for individuals living in outlying neighborhoods or those with mobility limitations. Convenience and long wait times were cited as additional deterrents to seeking care, with residents often forgoing services when scheduling or access was too complex. Participants emphasized the need for expanded access to co-located or integrated services, such as combining primary care with behavioral health, housing assistance, and social supports. Interviewees also stressed the importance of cultural and linguistically responsive care to build trust among patients. Without intentional efforts to address these gaps, many residents will remain disconnected from the care they need.

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. About one in twenty Cuyahoga residents (5.5%) do not have health insurance. Although this rate is lower than the Ohio and U.S. rates, Cuyahoga's Hispanic/Latino and American Indian/Alaska Native populations experience more than double the general county-wide uninsured rate (11.3% and 12.4%, respectively). Even for the county's Medicare population, healthcare access is a challenge. The county's rate for preventable hospital stays (3,677 per 100,000 Medicare enrollees) is in the highest quartile of all U.S. counties, and the county's Black/African American and Hispanic/Latino Medicare populations experience especially high rates of hospital stays that could have been avoided with routine care (5,651 and 5,458 per 100,000 Medicare enrollees, respectively).

Geospatial data from Conduent HCI's Community Health Index (CHI) further underscore the magnitude of access challenges. The CHI estimates health risk based on health-related social needs associated with preventable hospitalizations and poor health outcomes. Within the Fairview Hospital community, the highest scoring zip code was 44102 (Detroit-Shoreway), with an index value of 95.9. Notably, this zip code received the highest index value in the region for all three of Conduent HCI's Community Health Indices, indicating a confluence of particularly high needs around general health outcomes as well as food access and mental health, specifically. These findings demonstrate that barriers to healthcare are not only widespread across the community, but are also particularly concentrated in certain geographies and communities in the area served by Fairview Hospital. Additional details including charts, maps, and additional findings from primary and secondary data for this health need can be found in the appendices section of this report.

Prioritized Health Need #2: Behavioral Health



In the Fairview Hospital 2025 CHNA, Behavioral Health, including both mental health and substance use, was identified as a top priority due to its widespread impact and the significant gaps in prevention, treatment, and recovery services across the community. Participants emphasized that mental health conditions, including depression, anxiety, and trauma, are widespread and often exacerbated by social isolation, housing instability, poverty, community violence, and chronic stress. These challenges were described as especially acute in the aftermath of the COVID-19 pandemic, which both intensified existing mental health concerns and overwhelmed already strained behavioral health systems. Stakeholders consistently pointed to severe workforce shortages and long wait times as major barriers, with many noting that youth, older adults, and low-income populations are especially susceptible. Stigma, coupled with a lack of cultural and linguistically appropriate services, were also identified as powerful deterrents that prevent residents from seeking timely and effective care.

Substance use and misuse, particularly related to opioids and fentanyl, was also identified as a persistent and escalating issue, disproportionately affecting communities already experiencing economic hardship and housing instability. Stakeholders stressed the urgent need for low-barrier treatment options, peer-to-peer supports, and harm reduction programs that are accessible and responsive to community needs. Trauma-informed care and early intervention were emphasized as critical, especially for children and adolescents exposed to chronic stress, community violence, or unstable family environments. Participants also called for expanded behavioral health funding, investment in school-based and community-embedded supports, and stronger coordination between healthcare systems, housing agencies, and social service organizations. Without these integrated, community-centered strategies, many residents will remain disconnected from prevention and recovery services and at heightened risk of behavioral health crises.

Secondary data also indicate behavioral health concerns across Cuyahoga County. The average resident reports 6.0 mentally unhealthy days in the past 30 days, a rate which is higher than most other U.S. counties. Additionally, 17.5% of residents report experiencing two weeks or more of poor mental health in a month. Among Medicare recipients, depression rates are notably high within specific populations. For example, 33% of American Indian/Alaska Native Medicare beneficiaries in the community experience depression, more than double the county rate (16%).

Geographic analysis using Conduent HCI's Mental Health Index (MHI), which assesses mental health risk based on local health-related social need indicators, demonstrates a significant burden of behavioral health needs across the Fairview Hospital community. Most zip codes scored above 80 on the MHI scale, indicating severe challenges throughout the community. The 44102 zip code in Cleveland's Detroit-Shoreway neighborhood had the highest index score (98.5) in the region, highlighting a concentrated area of behavioral health need.

Cuyahoga County's drug poisoning death rate (45.5 per 100,000) exceeds the Ohio average (44.7) and is more than twice the Healthy People 2030 target (20.7). Alcohol-related harm is also pronounced, with 42.5% of the county's driving deaths involving alcohol, among the highest rates nationally. These data reflect both the prevalence and severity of substance use issues.

Together, these primary and secondary findings highlight the profound and intersecting challenges of mental health and substance misuse within the Fairview Hospital community.

Prioritized Health Need #3: Chronic Disease Prevention and Management

Chronic Disease Prevention & Management

Key Themes from Community Input

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

Warning Indicators

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

Chronic Disease Prevention and Management emerged as a top priority in the Fairview Hospital 2025 CHNA due to its high prevalence, disproportionate burden on certain populations, and strong connection to lifestyle, environment, and other health-related social needs. Stakeholders emphasized that conditions such as diabetes, heart disease, cancer, hypertension, and kidney disease remain leading causes of death and disability, yet many are preventable or manageable with early detection, sustained care, and supportive environments. Chronic disease management was described as inseparable from broader social and economic conditions, with poverty, unsafe neighborhoods, food insecurity, and limited access to preventive services all identified as factors that increase disease risk and complicate management.

Participants also highlighted systems-level barriers that prevent residents from effectively managing chronic illness. Affordability was a recurring concern, with co-pays, medication costs, and follow-up care often cited as prohibitive, even for insured patients. Long wait times and fragmented care delivery discourage routine monitoring, while technology limitations and lack of navigation support further limit engagement with preventive services. Stakeholders underscored the importance of culturally responsive education, community health workers, and co-located services that address both medical and social needs, such as nutrition, housing stability, and behavioral health. Without expanded access to affordable, coordinated, and community-based care, residents will continue to experience avoidable complications and uneven health outcomes tied to chronic disease.

The following subsections highlight key primary and secondary data findings. Findings across all subtopics, including nutrition, cancer, cardiovascular disease, and aging, highlight persistent barriers tied to income, race, geography, and systems of care.

Nutrition, Healthy Eating, and Wellness
Stakeholders emphasized the strong connection between nutrition, wellness, and the prevention of chronic disease. Access to healthy food and opportunities for physical activity were described as foundational to maintaining health and preventing conditions such as obesity, diabetes, and hypertension. Participants noted that many residents, particularly in low-income neighborhoods, lack access to fresh produce or affordable, nutritious options. Community members are often forced to rely on fast food or corner stores, contributing to poor dietary habits. Stakeholders expressed support for expanded community gardens, farmers markets, and health education programming that promotes wellness and long-term lifestyle change.

Secondary data findings support these insights. Wellness and Lifestyle ranked as the sixth highest scoring health topic in Cuyahoga County and Nutrition and Healthy Eating followed closely with a ranking of ninth. Conduent HCI's Food Insecurity Index (FII) can help to identify areas with greater levels of food hardship. Across the Fairview Hospital community, the highest scoring zip code is 44102 (Detroit-Shoreway) with a score of 96.4. Across Cuyahoga County, broadly, residents are more likely to rely on fast food and less likely to cook at home than the overall Ohio and U.S. populations. These patterns are linked to increased chronic disease risk.

Cancer
While cancer was not a dominant theme across all interviews, it was identified as a concern, particularly in the context of preventive care. Stakeholders pointed to the importance of regular screenings, early detection, and community-based health fairs as effective ways to reach residents who might not otherwise engage with the healthcare system. However, gaps in awareness and affordability were cited as reasons why individuals delay or avoid screenings. Some participants expressed concern about differences in health outcomes for different groups, highlighting the need for targeted outreach and culturally relevant education to promote cancer prevention and treatment access.

Secondary data reveal that Cuyahoga County has elevated incidence rates for both prostate and breast cancer relative to national averages. Prostate cancer occurs at a rate 23% higher than the U.S. average (139.3 vs. 113.2 per 100,000 males), while breast cancer is 5% more common (136.1 vs. 129.8 per 100,000 females). Notably, while screening rates in the county meet or exceed national benchmarks, mortality rates are especially high. Additionally, Black/African American residents of Cuyahoga County experience significantly higher mortality rates from both prostate and breast cancer than the overall county population. This suggests potential differences in access to timely diagnosis, treatment, or follow-up care.

Diabetes, Heart Disease, Stroke, and Other Chronic Conditions
Chronic conditions such as diabetes, hypertension, and cardiovascular disease were described as widespread throughout the community. Stakeholders emphasized that these conditions are often preventable but are poorly managed due to barriers such as

lack of access to care, limited health literacy, and cost-related medication nonadherence. Several stakeholders noted that community members frequently encounter these health issues through informal screening opportunities at events or clinics rather than through primary care. There was strong support for expanding chronic disease self-management education and ensuring that individuals have consistent follow-up care and support in managing their conditions over time.

Secondary data reinforce these concerns. Diabetes affects about one in ten adults in Cuyahoga County, and data from Medicare recipients reveal disproportionately high rates of diabetes among the county's Black/African American, Hispanic/Latino, and Asian American/Pacific Islander populations. Cuyahoga County's death rate due to kidney disease, a concern often related to unmanaged diabetes, is 20% higher than that of Ohio (18.0 vs. 15.1 deaths per 100,000). Chronic kidney disease is also particularly common in Cuyahoga County (20% of Medicare recipients), and is significantly more common among the county's Black Medicare recipients (30%).

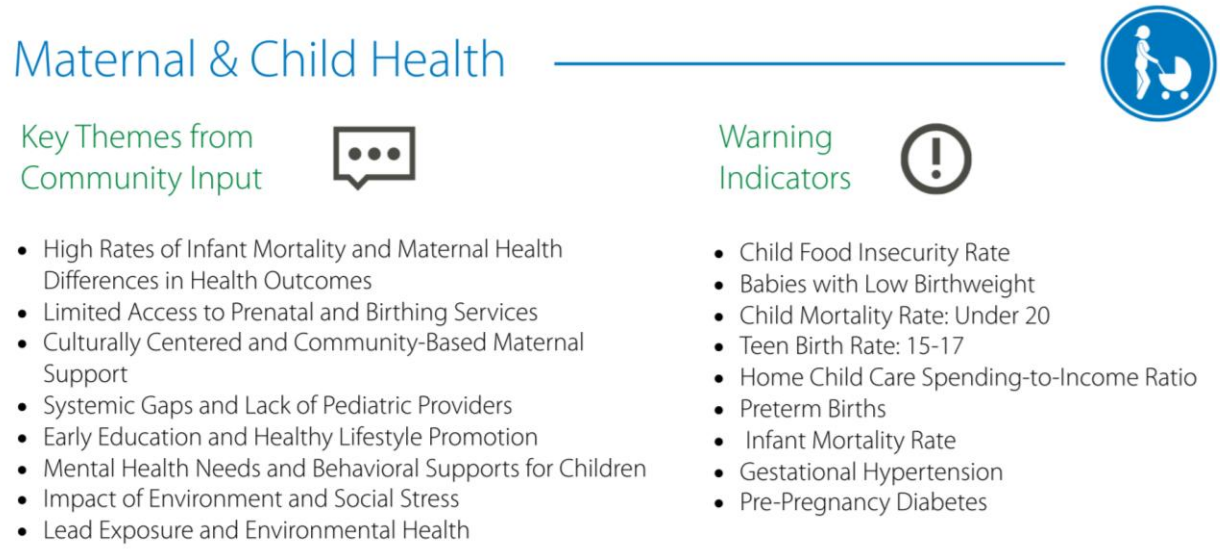
Stroke mortality in Cuyahoga County is 40.8 per 100,000, lower than the state average but still above the Healthy People 2030 goal (33.4). About two-thirds of Cuyahoga's Medicare recipients have hypertension (66%), and hypertension is especially common among the county's Black Medicare recipients (74%).

Older Adult Health

Older adults were identified as a priority population for chronic disease management. Stakeholders described increasing rates of isolation, cognitive decline, and mobility issues among seniors in the Fairview Hospital community. Many older adults face difficulty accessing routine care or managing multiple chronic conditions due to transportation barriers, affordability, and limited caregiver support. Participants stressed the importance of aging-in-place support, accessible preventive care, and programs that address both physical and mental health needs in this population. Investment in community-based services tailored to seniors was seen as essential to improving quality of life and reducing avoidable hospital visits.

Based on secondary data indicator scoring, the topic Older Adult Health is ranked as the fourth most concerning health topic in Cuyahoga County. Over one-third of the county's population aged 65+ live alone (36.1%), and 12.3% live below the federal poverty level, both figures exceeding national rates. Day care for older adults is also especially costly in Cuyahoga County, costing the average consumer 13.4% of their household income. This rate is higher than both Ohio and U.S. averages. These factors, combined with transportation and care coordination barriers, place older adults at elevated risk for unmanaged chronic illness.

Prioritized Health Need #4: Maternal and Child Health



In the Fairview Hospital 2025 CHNA, Maternal and Child Health was identified as a top priority based on both compelling stakeholder input and concerning population-level data for the hospital's surrounding communities. Maternal and child health is a foundational element of population health and a key indicator of community wellbeing. Outcomes in this domain, including maternal morbidity, infant mortality, birth complications, and child development, are strongly predictive of future health, educational achievement, and economic opportunity. Persistent gaps in maternal and child health were repeatedly tied to poverty, housing instability, limited access to comprehensive insurance, and unequal access to high-quality obstetric and pediatric care.

Stakeholders emphasized that maternal and infant health outcomes are shaped by a combination of social, environmental, and healthcare system factors. Participants raised concerns about the differences in prenatal and postpartum outcomes for some communities. Barriers included the absence of nearby birthing facilities for some neighborhoods, unreliable transportation, and limited pediatric provider availability. Several respondents stressed that chronic health conditions such as hypertension, obesity, and diabetes increase risks during pregnancy and contribute to poor birth outcomes. Mental health during and after pregnancy also emerged as a critical concern, with stakeholders underscoring the need for more integrated behavioral health and trauma-informed supports within prenatal and primary care settings. Community-based resources, including doulas, home visiting programs, and culturally grounded initiatives were highlighted as trusted models for supporting mothers holistically from pregnancy through postpartum recovery.

Children's health also emerged as a critical priority, particularly in relation to preventive services, nutrition, and safe, supportive environments. Stakeholders voiced concern about rising behavioral and emotional health issues in children and adolescents, which have been exacerbated by community violence, housing instability, and the lingering effects of the COVID-19 pandemic. Gaps in pediatric behavioral health care, including

long wait times, shortages of providers, and insufficient school-based services, were described as urgent challenges. Participants stressed the importance of early childhood education, school health programs, and wraparound services that address children's physical, emotional, and developmental needs. Coordinated efforts between healthcare systems, schools, and community-based organizations were viewed as essential to reducing differences in outcomes and ensuring that children in the Fairview Hospital community have the resources to thrive.

Secondary data findings for the community further affirm the significance of Maternal and Child Health challenges. Related health indicators were scored under two subtopics: Children's Health and Maternal, Fetal, and Infant Health. Based on these scores, Children's Health ranked as Cuyahoga's third most concerning health topic, and Maternal, Fetal, and Infant Health ranked eighth.

The county's teen birth rate (7.3 per 1,000 females aged 15–17), while improving, remains higher than most other Ohio counties. When compared to Ohio, Cuyahoga County has more concerning rates of gestational hypertension (22.3% vs. 18.3%) and pre-pregnancy diabetes (4.8% vs. 4.2%). All of these are known risk factors for adverse birth outcomes.

Cuyahoga County also has more concerning rates than Ohio with regard to both preterm births (12.0% vs. 10.8%) and infant mortality (7.7 vs. 6.7 deaths per 1,000 live births). The rate of preterm births is even higher among the county's Black/African American population (14.8%). Given the strong association between preterm birth and infant mortality, these figures raise serious concerns, particularly within the communities served by Fairview Hospital.

The mortality rate for individuals under 20 years of age in Cuyahoga County (70.8 deaths per 100,000) is among the highest in the state of Ohio. The county's Black/African American population of children experiences nearly twice this mortality rate (129.1). Some of the factors which may drive these high rates of child mortality include high rates of youth who are disconnected from school and work coupled with high rates of violent crime in the county. Environmental exposures further exacerbate risks: 15.7% of Cuyahoga households face severe housing problems, and the county maintains one of the highest childhood lead exposure rates in Ohio, despite some improvements in recent years.

Prioritized Health Need #5: Health-Related Social Needs



In the 2025 CHNA for Fairview Hospital, health-related social needs emerged as a critical priority due to their pervasive and compounding impact on nearly every other area of health concern, including behavioral health, chronic disease, maternal and child health, and healthcare access. Health-related social needs are among the most powerful influencers of health across the lifespan. Factors such as income, education, employment, housing stability, digital access, and neighborhood safety shape individuals' ability to engage in healthy behaviors, access healthcare, and manage chronic stress.

Stakeholders consistently emphasized that health outcomes in the Fairview Hospital community are deeply shaped by poverty and limited economic opportunity. Interviewees identified persistent barriers related to income, education, housing, transportation, digital connectivity, and neighborhood safety that contribute to poor health and constrain opportunities for individuals and families to thrive. Concerns about economic stability and job access were common, with residents linking income insecurity and unaffordable housing to stress, chronic illness, and instability across families. Transportation barriers, including limited public transit and unreliable infrastructure, further restrict access to healthcare, education, and employment. Environmental risks such as blight, lack of safe recreational spaces, and exposure to community violence were frequently cited as threats to both physical and mental health.

Education was also recognized as a core driver of long-term health and opportunity. Stakeholders described schools as critical touchpoints for children and families, noting the importance of early learning, school-based supports, and wraparound services that

extend beyond the classroom. However, differences in school quality and access to resources continue to shape outcomes across generations. Community members stressed that improving health requires cross-sector collaboration and sustained investment in upstream solutions, including early childhood education, workforce training tied to healthcare and local industries, affordable housing, and neighborhood safety initiatives. Feedback highlighted a shared belief that sustainable health improvement will require bold, coordinated efforts at the community level.

Secondary data findings further validate the concerns raised by community stakeholders. Health-related social need indicators, measured across the areas of prevention and safety, education, economy, and community, ranked among the highest areas of concern in Cuyahoga County. Notably, the Economy (score: 1.90) and Education (score: 1.72) were ranked among the top three quality of life indicator categories within the secondary data analysis. This indicates greater opportunities for improvement and positive impact within these areas in the Fairview Hospital community.

Violence and crime rates are especially concerning in Cuyahoga County. The violent crime rate (856.5 per 100,000 residents) is more than double Ohio's, and the homicide rate (20.7 per 100,000) is similarly twice the state's rate. Firearm-related deaths (20.2 per 100,000) further compound the community safety crisis. This rate places Cuyahoga among the highest quartile of U.S. counties for firearm-related fatalities, highlighting the impact of violence on both mortality and community trauma.

The Fairview Hospital Community also experiences economic hardship, which has broad impacts on community health. More than one in ten households (11.2%) in the community live below the federal poverty level, and this poverty is especially concentrated in the zip code 44102, the third most populous zip code in the Fairview Hospital community, where one in four households (25.7%) live below poverty. The cost of basic needs, such as housing (19.3% of household income for renters), health insurance (7.1%), adult day care (13.4%), and early education (8.7%), outpaces both state and national averages, leaving many families in the community with limited resources for healthcare, food, or transportation. Additionally, the Black/African American, Hispanic/Latino, and Native American/Alaskan Native populations of the Fairview Hospital community all report lower median household incomes than the general population.

Prioritized Health Needs in Context

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

Secondary Data Overview

Demographics and Health-Related Social Needs

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

Geography and Data Sources

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

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

Population Demographics of the Fairview Hospital Community

The Fairview Hospital community is situated within Cuyahoga County. This community has an estimated population of 451,116 persons, which is just over a third of the total Cuyahoga County population (1,228,231 persons). The median age in the community is 41.5 years, which is similar to the overall Cuyahoga County median age (41.4 years) and somewhat older than that of Ohio (40.3 years). More than a quarter of individuals are between 25-44 years old (28.7%).

Most of the Fairview Hospital community is White (73.1%), 13.0% of the population is Hispanic or Latino, and 9.0% are Black/African American. The hospital community has a higher percentage of White residents than the overall Cuyahoga County population (73.1% vs. 57.3%) and a higher percentage of Hispanic/Latino residents (13.0% vs.

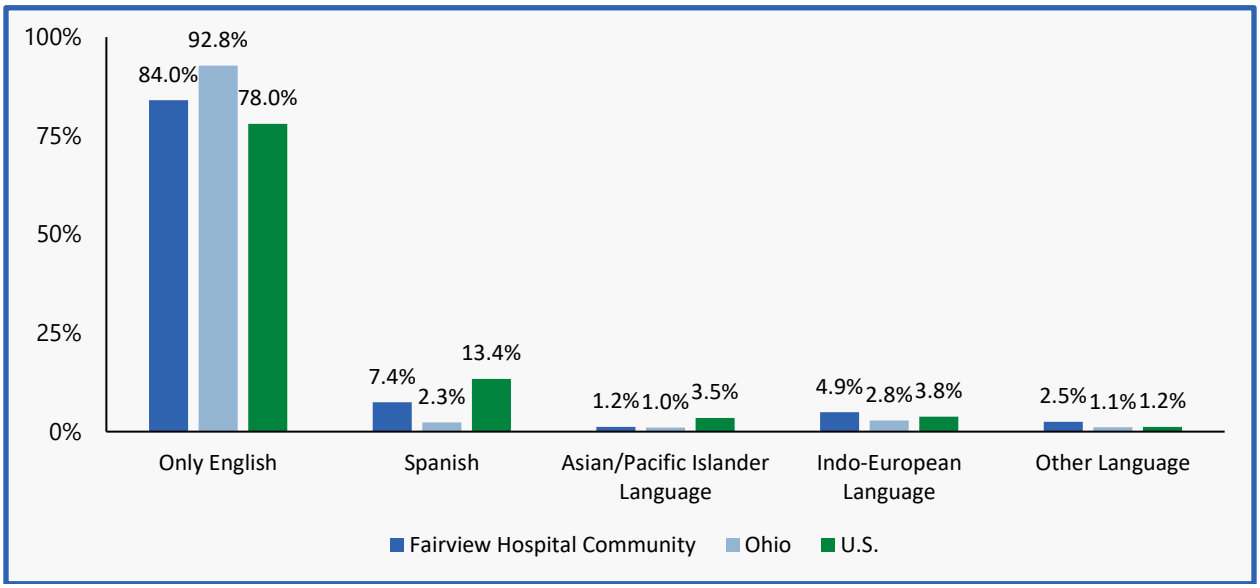
[2] National Academies Press (US); 2002. 2, Understanding Population Health and Its Determinants. Available from: https://www.ncbi.nlm.nih.gov/books/NBK221225/

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

7.3%), as well as a smaller percentage of Black/African American residents (9.0% vs. 29.2%).

Among those aged five and above, 16.0% speak a language other than English at home, including 7.4% who speak Spanish in the Fairview Hospital Community (Figure 2). Understanding countries of origin and language spoken at home can help inform the cultural and linguistic context for the health and public health system. Primary language spoken in the home can also be a proxy for acculturation into the community.

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



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

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

There has been a steady increase of the Hispanic/Latino population in Cuyahoga County in particular. Based on American Community Survey 5-Year estimates, between 2013 and 2023 there was a 1.9% increase in the Hispanic or Latino population in Cuyahoga County.

Income and Poverty

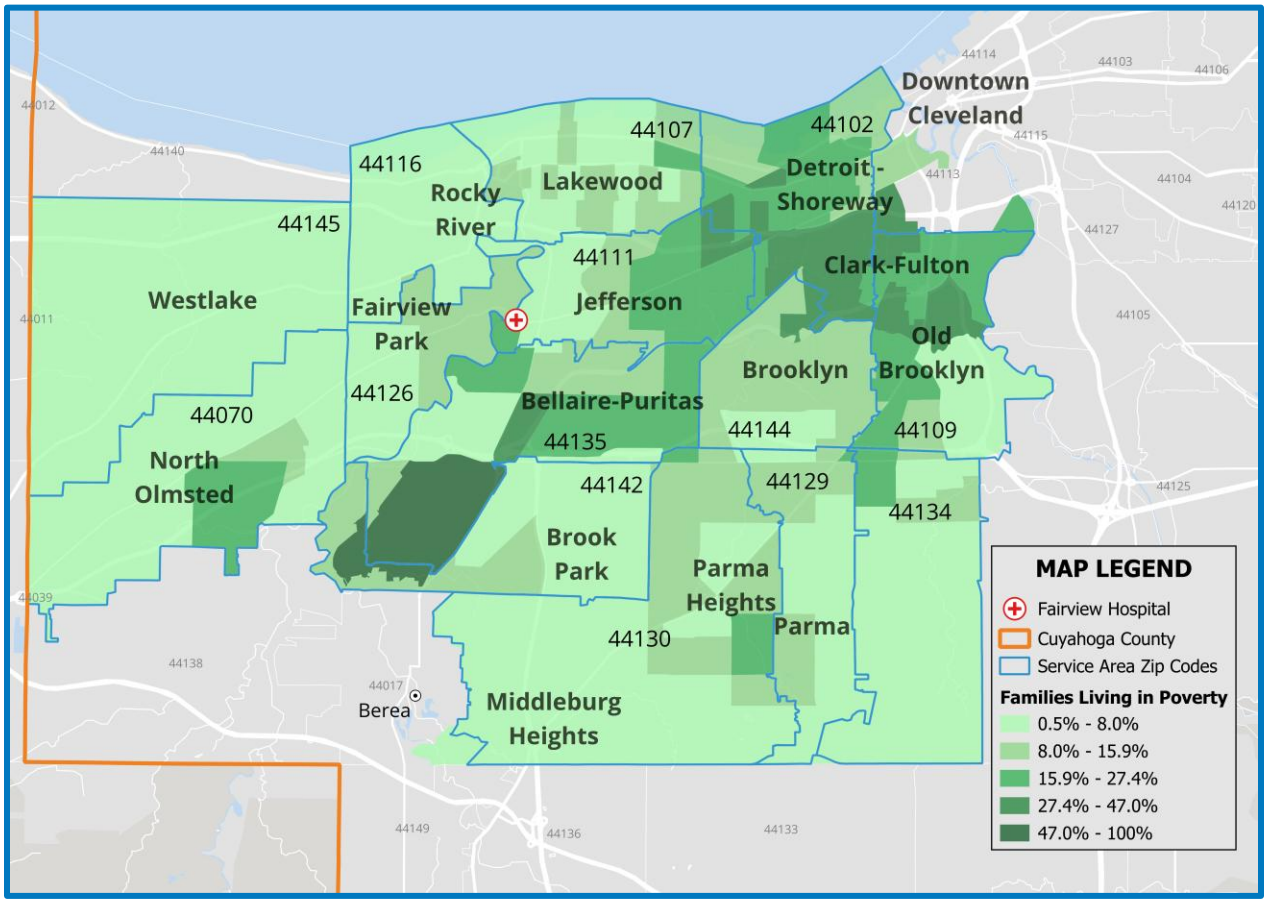
The median household income for the Fairview Hospital Community is $62,740, which is somewhat lower than the overall median income for Ohio ($68,488).

Federal poverty thresholds are set every year by the Census Bureau and vary by size of family and ages of family members. Overall, 11.2% of families in the Fairview Hospital Community live below the poverty level, which is higher than the state value (9.4%). Within the Fairview Hospital community, poverty is most concentrated in the zip code 44102 (Cleveland) where a quarter of families (25.7%) live below the poverty level (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 in Poverty by Census Tract, Fairview Hospital Community



Claritas Pop-Facts® (2024 population estimates)

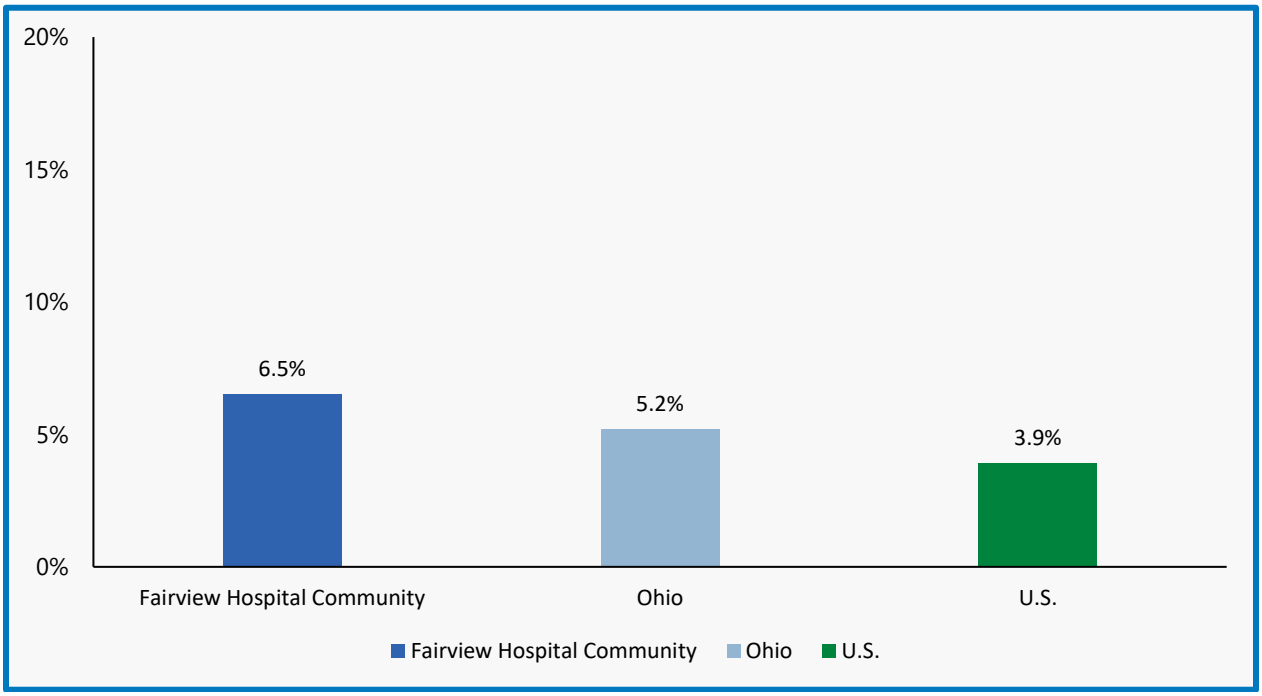
Education and Employment

The majority of the population within the Fairview Hospital community has a high school degree or higher (89.6%), similar to both the Ohio and U.S. high school graduate rates (91.4% and 89.4%, respectively). Nearly a third of the Fairview Hospital community has a bachelor's degree or higher (30.9%), which is a lower rate than the surrounding Cuyahoga County (34.8%), but similar to the Ohio population (30.1%).

The Fairview Hospital community has an unemployment rate of 6.5% (Figure 4). This unemployment rate, as well as that of the surrounding Cuyahoga County (7.3%), are both higher than that of the Ohio population (5.2%), and each of these rates is higher than that of the U.S. population (3.9%).

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

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



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

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

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

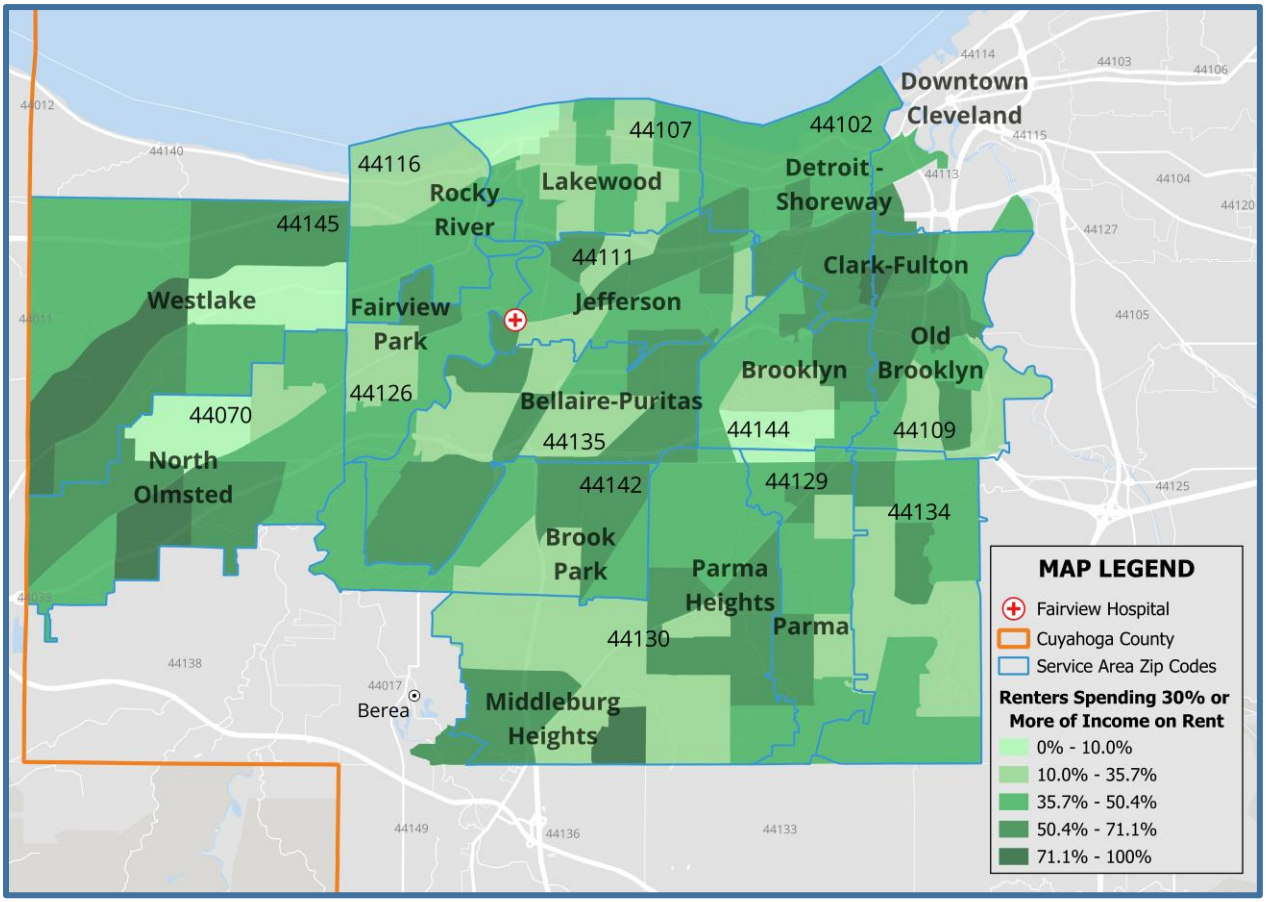
Housing and Built Environment

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

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

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

Figure 5: High Rent Burden by Census Tract, Fairview Hospital Community



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

Home internet access is an essential home utility for accessing healthcare services, including making appointments with providers, getting test results, and accessing medical records. The majority of the Cuyahoga population has internet access (87.5% of households). However, at the zip code level, the lowest levels of internet access in the Fairview Hospital community are in the zip codes 44102 (Detroit-Shoreway) and 44109 (Brooklyn-Centre), where the percentage of households with internet are 81.8% and 81.7%, respectively.

Community Health Indices

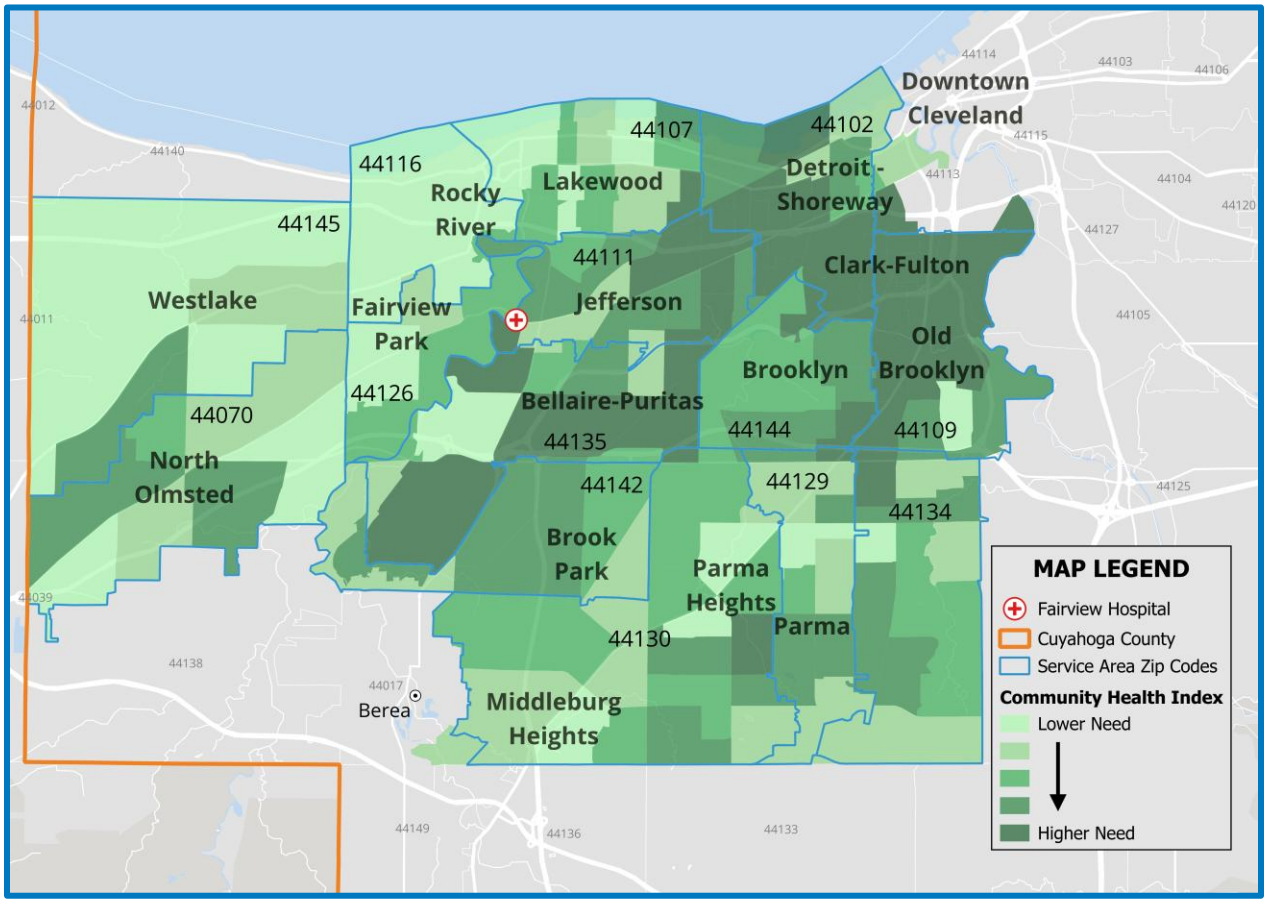
A map index that visualizes social and economic drivers of health at a specific geographic level serves as a critical decision-making tool by highlighting localized differences in health outcomes that may be obscured in broader geographic analyses. The three indices below highlight differences in community health outcomes, mental health outcomes, and food insecurity for the Fairview Hospital community at the census tract 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 data on social needs and demographic characteristics that are 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 Fairview Hospital community, as indicated by the darkest shade of green. At the zip code level, 44102 (Detroit-Shoreway) has the highest index value of the Fairview Hospital Community. See Appendix B for additional details about the CHI and a table of CHI values for each zip code in the Fairview Hospital community.

Figure 6: Community Health Index by Census Tract, Fairview Hospital Community

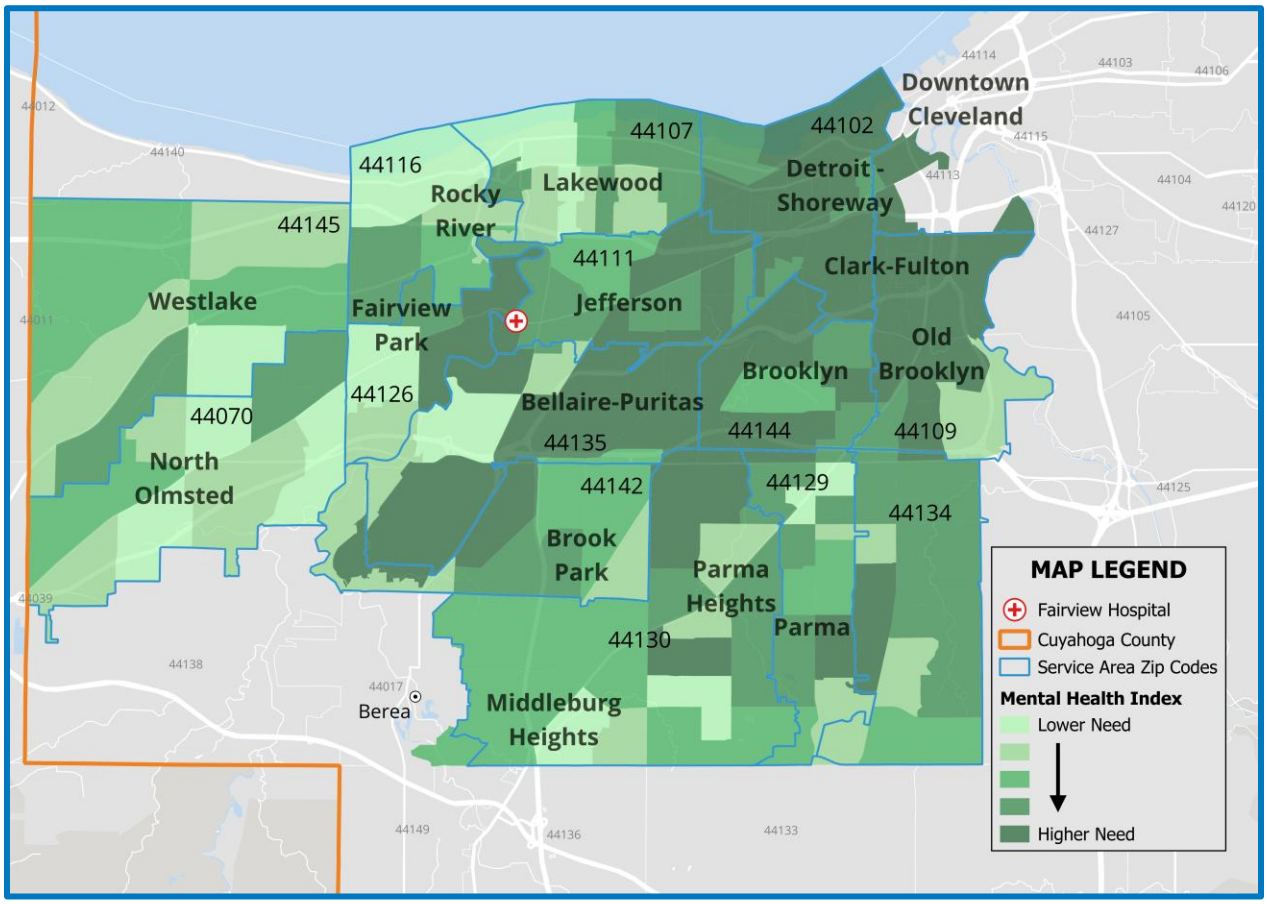


Mental Health Index

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

Figure 7 illustrates which census tracts experience the greatest relative need related to mental health in the Fairview Hospital Community, as indicated by the darkest shade of green. At the zip code level, 44102 (Detroit-Shoreway) has the highest index value of the Fairview Hospital Community. See Appendix B for additional details about the MHI and a table of MHI values for each zip code in the Fairview Hospital community.

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

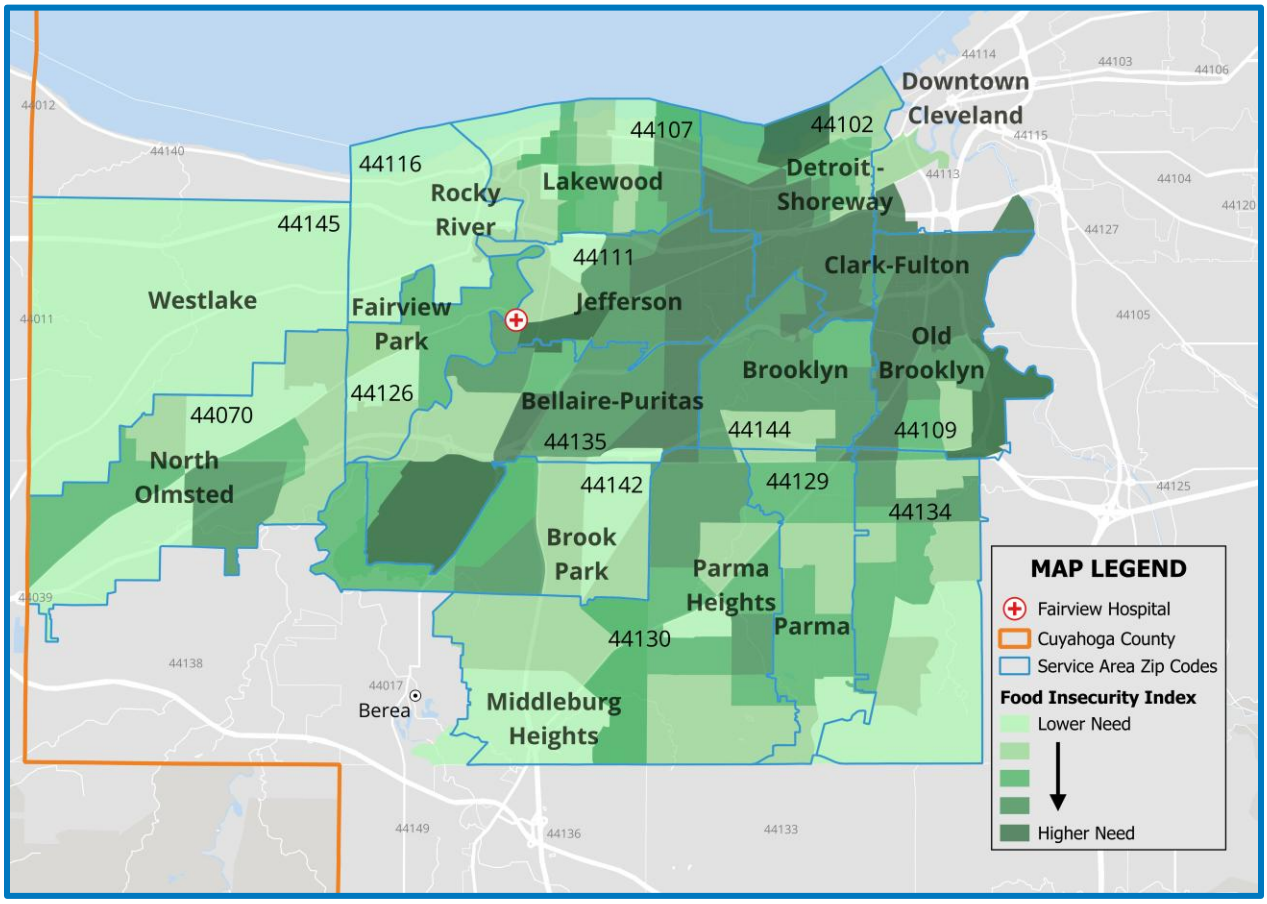


Food Insecurity Index

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

Figure 8 illustrates which census tracts experience the greatest relative need related to food insecurity in the Fairview Hospital Community, as indicated by the darkest shade of green. At the zip code level, 44102 (Detroit-Shoreway) has the highest index value of the Fairview Hospital Community. See Appendix B for additional details about the FII and a table of FII values for each zip code in the Fairview Hospital community.

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



Other Community Assessment and Improvement Plans

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

2023 Ohio State Health Assessment[7]

The following points summarize the key alignment between the 2023 Ohio State Health Assessment and Fairview Hospital'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 cultural and linguistically appropriate care.
- Behavioral Health:
    - Increased rates of depression, anxiety, and suicide among both youth and adults.
    - Significant unmet mental health needs and high levels of substance use, including youth drug use and adult overdose deaths.
- Chronic Disease Prevention and Management:
    - Statewide increases in diabetes and continued high rates of heart disease and hypertension.
    - Obesity and poor nutrition are identified as key contributors to chronic conditions.
- Maternal and Child Health:
    - Stagnant or worsening maternal morbidity and infant mortality rates.
    - Persistent differences in birth outcomes.
- Health-Related Social Needs:
    - Ongoing challenges related to poverty, housing affordability and quality, food insecurity, and transportation.
    - These social drivers of health are strongly linked to poor health outcomes across all priority areas.

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

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

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

2024 Cuyahoga County ADAMHS Board Needs Assessment[9]

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

2023 Cuyahoga County Planning Commission Data Book[10]

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

---

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

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

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

2022 Greater Cleveland LGBTQ+ Community Needs Assessment[11]

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

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

Priority Health Areas Identified:

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

Prioritized Populations:

- Maternal, Fetal, and Infant Health
- Older Adults

2023 Livable Cuyahoga Needs Assessment[13]

Community & Health Services

- Cleveland has the highest disability rates among older adults in the county
- Access to doctors and hospitals is high, but other barriers persist

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

---

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

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

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

- Driving makes travel easy, but more medical transport options are needed

Housing

- Older adults want to age in place in Cuyahoga County
- Renters face higher housing cost burdens than homeowners
- Support needed to find housing that meets mobility and accessibility needs

Social Participation

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

Respect & Social Inclusion

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

Workforce & Civic Engagement

- Older job seekers face ageism and tech-related challenges
- Most plan to stay in the county after retirement
- Race and income impact voting accessibility

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

Economic Mobility

- Most children are unprepared for kindergarten; enrollment in preschool is lower for some 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

- Differences in life expectancy
- High levels of food insecurity and poor air quality
- Poor mental health outcomes; need for trauma-informed approaches

Housing Stability

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

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

Primary Data Overview

Community Stakeholder Conversations

A total of 19 organizations provided feedback for the Fairview Hospital community. Interviews with each stakeholder varied by individual and the amount of feedback they provided. They generally ranged from thirty to sixty minutes. A full write up of qualitative data findings and the community stakeholder facilitation guide can be found in Appendix D.

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

- ADAMHS Board of Cuyahoga County
- ASIA (Asian Services In Action)
- Benjamin Rose Institute on Aging
- Boys and Girls Clubs of Northeast Ohio
- City of Cleveland Department of Public Health
- City of Cleveland, Division of Fire
- Cleveland Clinic Children's
- Cuyahoga County Board of Health
- Cuyahoga Metropolitan Housing Authority
- Esperanza
- Fairview Park Schools
- First Year Cleveland
- Greater Cleveland Food Bank
- Lead Safe Cleveland Coalition
- LGBTQ+ Assessment Greater Cleveland / Cleveland Clinic
- NAMI Greater Cleveland
- Neighborhood Family Practice (FQHC)
- West Park CDC
- West Park YMCA

Across the community stakeholder conversations, participants consistently emphasized the importance of addressing behavioral health, particularly mental health, and substance use, noting a lack of accessible and affordable services, especially for youth and low-income individuals. Access to care was also a significant concern. Participants referred to geographic barriers, service availability, affordability, and the need for culturally and linguistically appropriate care models. Chronic diseases such as diabetes and hypertension were mentioned frequently as well. These themes were often mentioned in connection with lifestyle factors, poor nutrition, and housing conditions.

Community stakeholders also discussed the importance of social and economic influences of health, including poverty, education, employment, transportation, and housing, as key drivers of health differences in the community. These factors were often described as interrelated, with housing instability and food insecurity further complicating residents' ability to manage chronic conditions or access routine care. Several stakeholders highlighted structural challenges such as underfunded services and

lower investment in certain communities. Trust in providers, lack of preventive care infrastructure, and limited service integration were also cited as significant barriers, underscoring the need for coordinated, community-based strategies to improve health outcomes across Cuyahoga County.

The following quotes highlight key themes highlighted in community feedback.

Priority Area	Key Quote	Additional Context
Access to Healthcare	"The first thing is services being accessible and close by. If someone has to take two busses to get care, they are not going to go."	Highlights how transportation and proximity to resources are major barriers to accessing timely healthcare.
Behavioral Health	"We've had families wait months just to get their child seen by a therapist and that is unacceptable".	Illustrates the shortage and long wait times for pediatric mental health services.
	"It's everywhere – fentanyl is in everything now, and people don't even know what they're taking."	Emphasizes the widespread impact of fentanyl and the dangers of unintentional substance use.
Chronic Disease Prevention and Management	"Access to food and exercise are contributing to things like diabetes and cancer."	Connects chronic disease outcomes to environmental and social factors like nutrition and physical activity.
Maternal and Child Health	"Black babies are twice as likely to die in Cuyahoga County...we have a very significant rate of infant mortality."	Underscores significant differences in outcomes in infant mortality.
Health-Related Social Needs	"Poverty is the cause of these problems... living in poverty creates stress and that hurts your health."	This succinctly summarizes the foundational role poverty plays in shaping health outcomes. It reflects stakeholder recognition that economic instability is a root cause influencing other critical issues, such as chronic disease, mental health, housing insecurity, and violence. It also reinforces the importance of upstream solutions in improving community health.

Prioritization Methodology

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

Collaborating Organizations

The fifteen regional hospitals within the Cleveland Clinic health system in Northeast Ohio collaborate to share community health data and resources throughout the CHNA and implementation strategy processes. Fairview Hospital is part of the Cleveland Clinic West Submarket which includes Lutheran, Fairview, and Avon hospitals.

Community Partners and Resources

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

Federally Qualified Health Centers and Health Departments

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

- Asian Services in Action, Inc.
- Care Alliance

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

- MetroHealth Community Health Centers
- Neighborhood Family Practice
- Northeast Ohio Neighborhood Health Services
- Signature Health, Inc.
- The Centers

Hospitals

In addition to several Cleveland Clinic hospitals in Northeast Ohio, the following is a list of other hospital facilities located in the Fairview Hospital community:

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

Other Community Resources

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

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

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

Comments Received on Previous CHNA

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

Request for Public Comment

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

Appendices Summary

A. Fairview Hospital Community Definition

B. Secondary Data Sources and Analysis

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

C. Environmental Scan and Key Findings

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

D. Community Input Assessment Tools and Key Findings

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

- Key Stakeholder Interview Questions
- Summary Qualitative Findings

E. Impact Evaluation

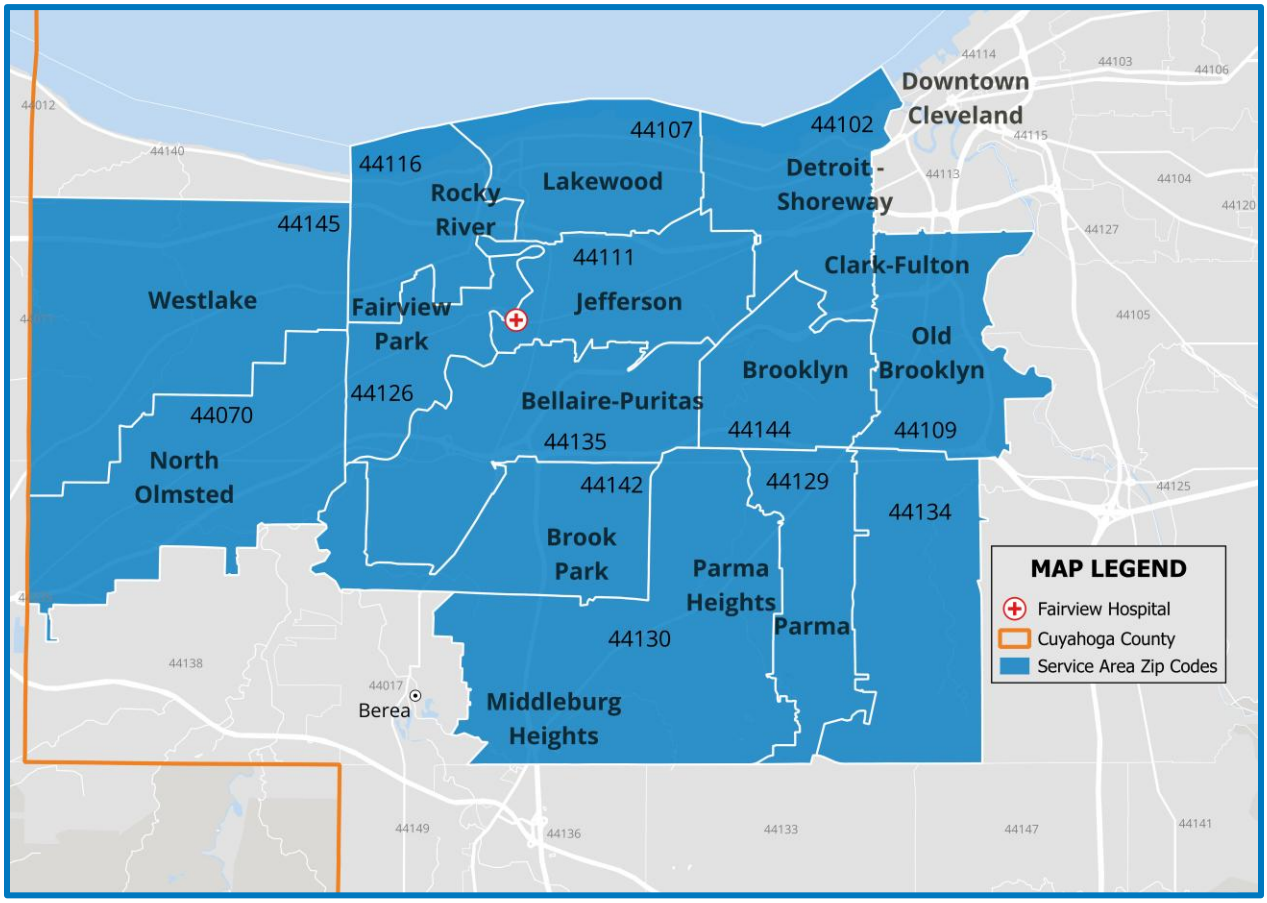
An overview of progress made on the 2022 Implementation Strategies.

F. Acknowledgements

Appendix A: Fairview Hospital Community Definition

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

Figure 9: Fairview Hospital Community Definition



Appendix B: Secondary Data Sources and Analysis

Secondary Data Sources & Analysis

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

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

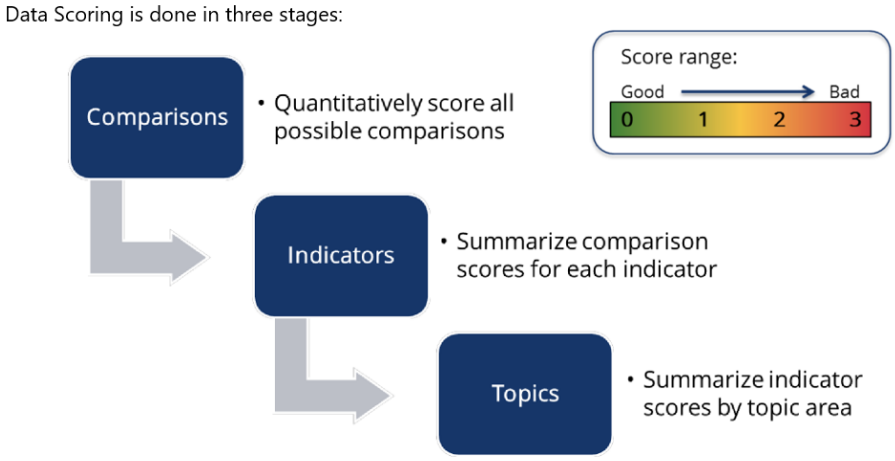
- American Community Survey
- American Lung Association
- Annie E. Casey Foundation
- CDC - PLACES
- Centers for Disease Control and Prevention
- Centers for Medicare & Medicaid Services
- Claritas Consumer Profiles
- Claritas Consumer Spending Dynamix
- County Health Rankings
- Early Ages Healthy Stages
- Feeding America
- National Cancer Institute
- National Center for Education Statistics
- National Environmental Public Health Tracking Network
- Ohio Department of Education
- Ohio 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 Fairview Hospital Community, this analysis was completed for Cuyahoga County. A complete breakdown of topic and indicator scores can be found below.

Comparison to a Distribution of County Values: State and Nation

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

Comparison to Values: State, National, and Targets

Each county is compared to the state value, the national value, and the target value. Target values are defined by 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 list of 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 health topics and all four quality of life topics scored at or above this threshold in Cuyahoga County (see Tables 2 and 3).

Topic Scores

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

Table 2: Health Topic Scores: Cuyahoga County

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

Respiratory Diseases	1.23
Women's Health	1.17
Oral Health	1.16
Tobacco Use	1.05
Physical Activity	0.96

Table 3: Quality of Life Topic Scores: Cuyahoga County

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

Conduent's SocioNeeds Index Suite®

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

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

Zip Code	CHI Value	FII Value	MHI Value
44070	38.2	40.6	62.9
44102	95.9	96.4	98.5
44107	41.2	49.4	77.2
44109	94.5	93.8	97.9
44111	86.9	90.5	94.6
44116	7.8	12.9	55.2
44126	33.8	42.7	66.6
44129	46.1	55.7	80.8
44130	50.5	54.0	82.6
44134	58.6	52.0	86.1
44135	90.7	92.0	97.4
44142	72.6	48.3	84.7
44144	77.3	83.6	93.2
44145	14.8	15.8	64.4

Census Tract Key

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

Figure 12: Census Tract Key (Fairview Hospital, West)

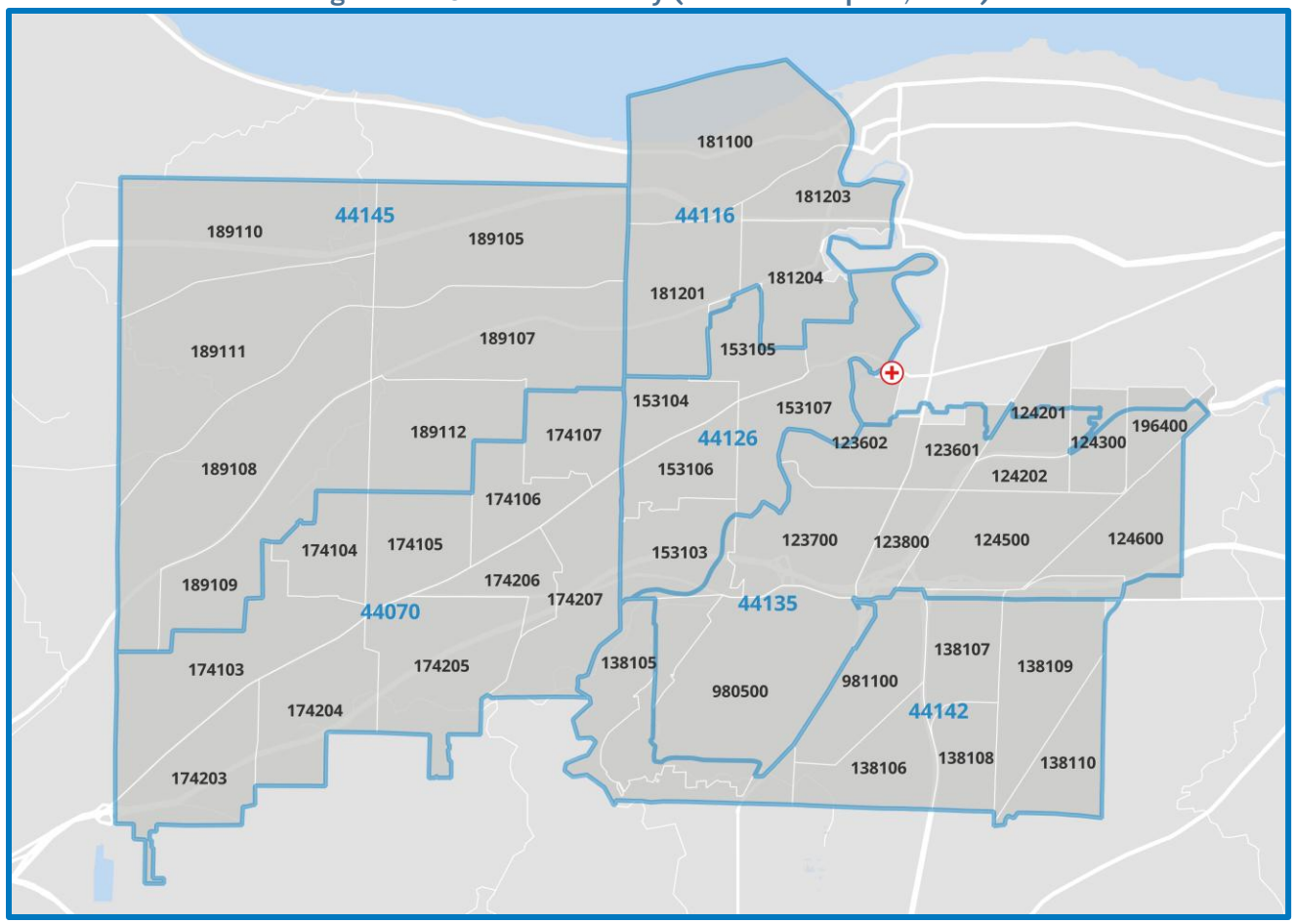


Table 5: Census Tracts by Zip Code (Fairview Hospital, West)

44070	44116	44126	44135	44142	44145
174103	1881100	153103	123601	981100	189105
174104	181201	153104	123602	138105	189107
174105	181203	153105	123700	138106	189110
174106	181204	153106	123800	138107	189111
174107	153105	153107	124201	138108	189108
174203			124202	138109	189112
174204			124300	138110	189109
174205			124500		
174206			124600		
174207			196400		
			138105		
			980500		

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

Figure 13: Census Tract Key (Fairview Hospital, East)

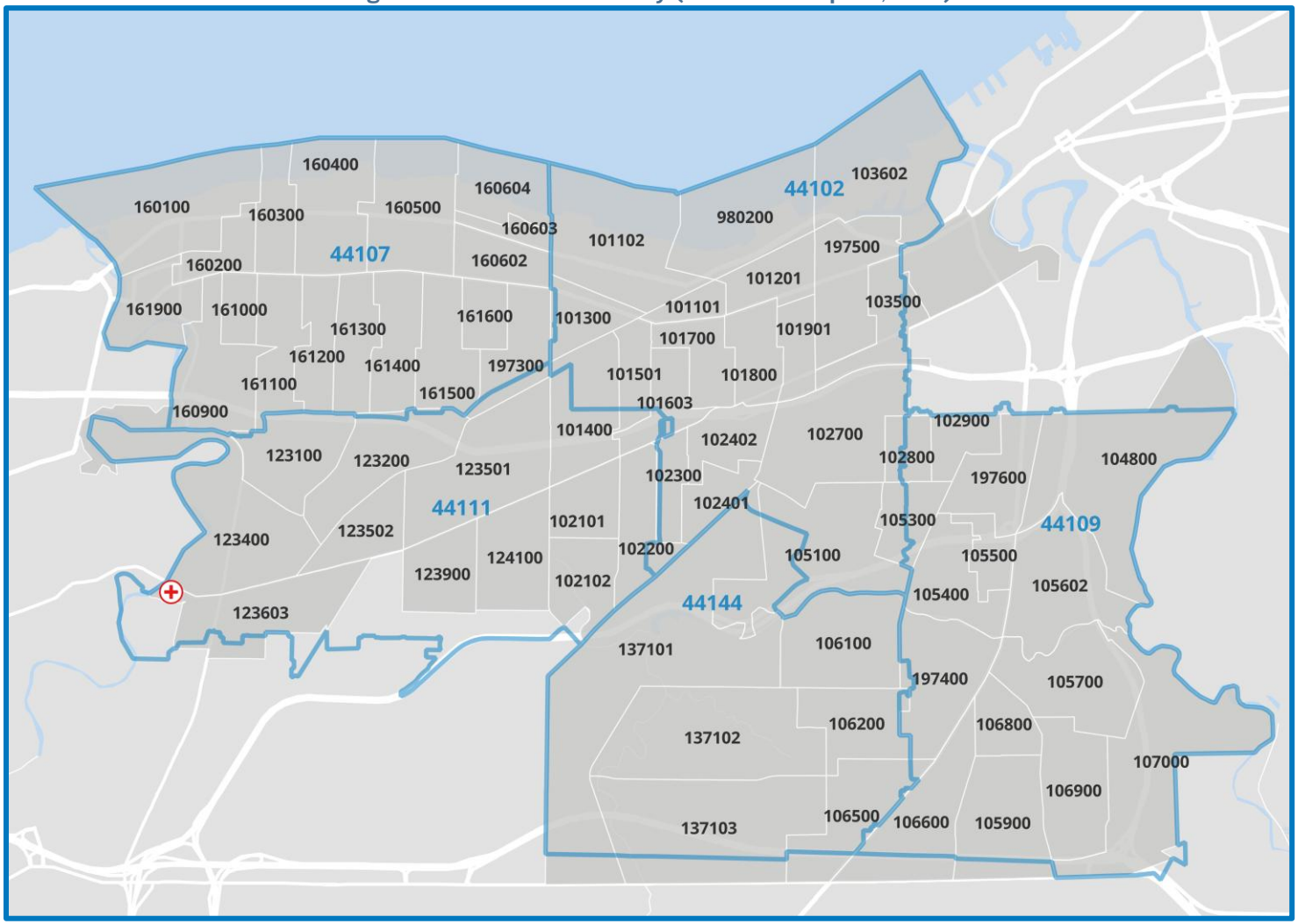


Table 6: Census Tracts by Zip Code (Fairview Hospital, East)

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

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

Figure 14: Census Tract Key (Fairview Hospital, South)

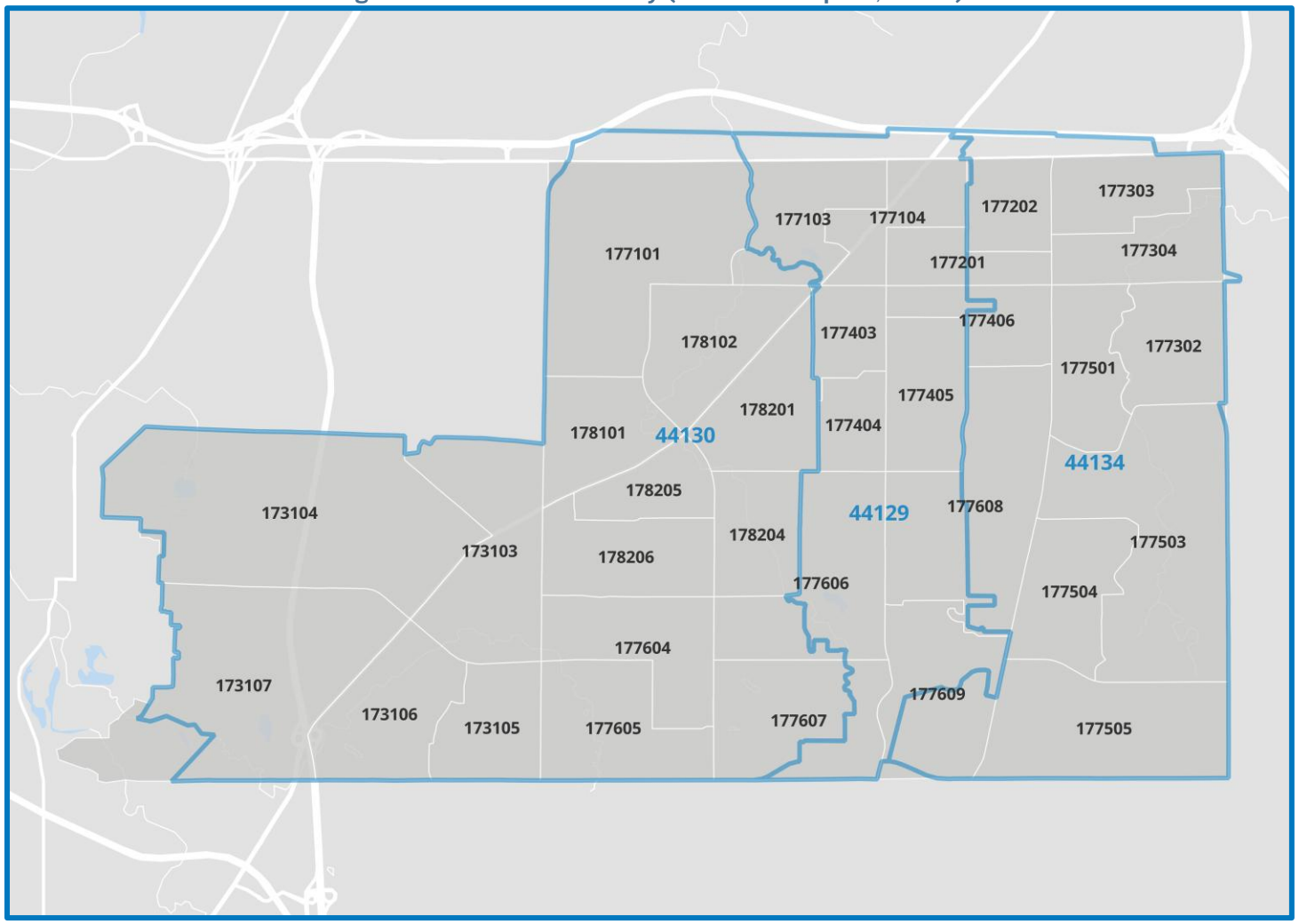


Table 7: Census Tracts by Zip Code (Fairview Hospital, South)

44129	44130	44134
177103	173103	177201
177104	173104	177202
177201	173105	177302
177202	173106	177303
177403	173107	177304
177404	177101	177406
177405	177103	177501
177406	177604	177503
177606	177605	177504
177607	177606	177505
177608	177607	177608
177609	178101	177609
	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 (CHI) considers validated indicators related to income, employment, education, and household environment to identify areas at highest risk for experiencing concerning health outcomes.

HOW IS THE INDEX VALUE CALCULATED?

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

WHAT DO THE RANKS AND COLORS MEAN?

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

Food Insecurity Index (FII)

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

HOW IS THE INDEX VALUE CALCULATED?

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

WHAT DO THE RANKS AND COLORS MEAN?

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

Data Considerations

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

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

Race or Ethnic and Special Population Groupings

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

Indicators of Concern for Prioritized Health Needs

Below are details regarding indicators of concern for all prioritized health needs discussed in this report. Each indicator includes a county-level value and standardized score, as well as the following comparison data, where available: state value, national value, state county distribution, national county distribution, and over-time trend. Table 8 describes how to interpret the icons used to describe county distributions and trend data.

Table 8: 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 9 below as a reference key for indicator data sources.

Table 9: 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 10: All Cuyahoga County Secondary Data Indicators

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

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

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

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

SCORE	ALCOHOL & DRUG USE	UNITS	CUYAHOGA COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.44	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	42.5		32.1		*2018-2022*	10
2.03	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate	*Deaths per 100,000 population*	39.2		40.4	23.5	*2018-2020*	6
1.94	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	45.5	20.7	44.7		*2020-2022*	10
1.76	Adults who Binge Drink	*percent*	18.1			16.6	*2022*	5
1.74	Adults who Drink Excessively	*percent*	21.0		21.2		*2022*	10
1.35	High School Students who Ever Misused Prescription Pain Medication	*percent*	9.5				*2023*	23
1.35	High School Students who Usually Used Marijuana by Smoking it as a Blunt	*percent*	54.8				*2023*	23
1.06	High School Students who Ever Drank Alcohol	*percent*	31.3				*2023*	23
1.06	High School Students who Ever Used an Illicit Drug	*percent*	2.1				*2023*	23
1.06	High School Students who Ever Used Marijuana	*percent*	24.7				*2023*	23
1.06	High School Students who Use Alcohol	*percent*	14.9				*2023*	23
1.06	High School Students who Use Marijuana	*percent*	15.4				*2023*	23
0.82	Liquor Store Density	*stores/ 100,000 population*	6.1		5.6	10.9	*2022*	27
0.62	Mothers who Smoked During Pregnancy	*percent*	3.8	4.3	7.9	3.7	*2022*	18

SCORE	CANCER	UNITS	CUYAHOGA COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
3.00	Prostate Cancer Incidence Rate	*cases/ 100,000 males*	139.3		118.1	113.2	*2017-2021*	13
2.24	Age-Adjusted Death Rate due to Prostate Cancer	*deaths/ 100,000 males*	23.2	16.9	19.3	19.0	*2018-2022*	13
2.21	Cancer: Medicare Population	*percent*	13.0		12.0	12.0	*2023*	7
2.00	Breast Cancer Incidence Rate	*cases/ 100,000 females*	136.1		132.3	129.8	*2017-2021*	13
1.76	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	21.9	15.3	20.2	19.3	*2018-2022*	13
1.71	All Cancer Incidence Rate	*cases/ 100,000 population*	476.4		470.0	444.4	*2017-2021*	13
1.41	Colon Cancer Screening: USPSTF Recommendation	*percent*	66.2			66.3	*2022*	5
1.41	Colorectal Cancer Incidence Rate	*cases/ 100,000 population*	40.2		38.9	36.4	*2017-2021*	13
1.24	Adults with Cancer (Non-Skin) or Melanoma	*percent*	8.3			8.2	*2022*	5
1.06	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	61.7		64.3	53.1	*2017-2021*	13
0.88	Age-Adjusted Death Rate due to Cancer	*deaths/ 100,000 population*	159.5	122.7	161.1	146.0	*2018-2022*	13
0.88	Age-Adjusted Death Rate due to Colorectal Cancer	*deaths/ 100,000 population*	13.8	8.9	13.9	12.9	*2018-2022*	13
0.88	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	36.6	25.1	39.8	32.4	*2018-2022*	13
0.88	Cervical Cancer Screening: 21-65	*Percent*	83.2			82.8	*2020*	5
0.88	Mammogram in Past 2 Years: 50-74	*percent*	78.7	80.3		76.5	*2022*	5
0.85	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	6.5		7.8	7.5	*2017-2021*	13

0.76	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	11.5		12.8	12.0	*2017-2021*	13
0.62	Mammography Screening: Medicare Population	*percent*	52.0		51.0	39.0	*2023*	7

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

1.35	Blood Lead Levels in Children (>=10 micrograms per deciliter; Count)	*children*	312				*2021*	19
1.35	Blood Lead Levels in Children (>=5 micrograms per deciliter; Count)	*children*	1,056				*2021*	19
1.32	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	5.5		2.0		*2021*	19
0.71	Child Care Centers	*per 1,000 population under age 5*	10.3		8.0	7.0	*2022*	10

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

2.26	Residential Segregation - Black/White	*Score*	71.5		69.6		*2025*	10
2.26	Social Associations	*membership associations/ 10,000 population*	8.9		10.8		*2022*	10
2.21	Adults Who Vote in Presidential Elections: Always or Sometimes	*percent*	83.4		84.9	85.1	*2024*	8
2.21	Age-Adjusted Death Rate due to Homicide	*deaths/ 100,000 population*	20.7	5.5	9.0		*2020-2022*	21
2.18	Linguistic Isolation	*percent*	2.7		1.5	4.2	*2019-2023*	2
2.12	Median Household Gross Rent	*dollars*	1,005		988	1,348	*2019-2023*	2
2.12	Mortgaged Owners Median Monthly Household Costs	*dollars*	1,529		1,472	1,902	*2019-2023*	2
2.00	Voter Turnout: Presidential Election	*percent*	65.7	58.4	71.7		*2024*	22
1.94	Children Living Below Poverty Level	*percent*	23.2		18.0	16.3	*2019-2023*	2
1.94	People 65+ Living Alone (Count)	*people*	85,788				*2019-2023*	2
1.94	People Living Below Poverty Level	*percent*	16.2	8.0	13.2	12.4	*2019-2023*	2
1.88	Violent Crime Rate	*crimes/ 100,000 population*	856.5		359.0		*2023*	20
1.85	Households with a Computer	*percent*	83.3		85.2	86.0	*2024*	8
1.76	Young Children Living Below Poverty Level	*percent*	24.9		20.0	17.6	*2019-2023*	2
1.74	Grandparents Who Are Responsible for Their Grandchildren	*percent*	38.9		41.3	32.0	*2019-2023*	2
1.68	Adults With Group Health Insurance	*percent*	36.0		37.4	39.8	*2024*	8
1.68	Gasoline and Other Fuels Spending-to-Income Ratio	*percent*	3.5		3.4	3.2	*2024*	9

1.59	Median Household Income	*dollars*	62,823		69,680	78,538	*2019-2023*	2
1.41	Substantiated Child Abuse Rate	*cases/ 1,000 children*	9.3	8.7	6.9		*2021*	4
1.35	High School Students who Did Not Go to School Because They Felt Unsafe at School or on Their Way To or From School	*percent*	9.1				*2023*	23
1.35	High School Students who were Threatened or Injured with a Weapon on School Property	*percent*	7.4				*2023*	23
1.24	Households with a Smartphone	*percent*	86.1		87.5	88.2	*2024*	8
1.24	Workers Commuting by Public Transportation	*percent*	3.3	5.3	1.1	3.5	*2019-2023*	2
1.18	Total Employment Change	*percent*	5.0		2.9	5.8	*2021-2022*	27
1.09	Persons with Health Insurance	*percent*	93.0	92.4	92.9		*2022*	28
1.06	Households with an Internet Subscription	*percent*	87.5		89.0	89.9	*2019-2023*	2
1.06	Households with One or More Types of Computing Devices	*percent*	93.1		93.6	94.8	*2019-2023*	2
1.06	People 25+ with a High School Diploma or Higher	*percent*	91.2		91.6	89.4	*2019-2023*	2
1.06	Persons with an Internet Subscription	*percent*	90.3		91.3	92.0	*2019-2023*	2
1.06	Population 16+ in Civilian Labor Force	*percent*	59.3		60.1	59.8	*2019-2023*	2
0.97	Digital Distress		1.0				*2022*	24
0.79	Adults With Individual Health Insurance	*percent*	21.8		20.5	20.2	*2024*	8
0.79	Digital Divide Index	*DDI Score*	19.4		40.1	50.0	*2022*	24
0.79	Solo Drivers with a Long Commute	*percent*	30.3		30.5		*2019-2023*	10

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

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

SCORE	ECONOMY	UNITS	CUYAHOGA COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.82	Median Monthly Owner Costs for Households without a Mortgage	*dollars*	654		570	612	*2019-2023*	2
2.82	People 65+ Living Below Poverty Level	*percent*	12.3		9.5	10.4	*2019-2023*	2
2.71	Child Food Insecurity Rate	*percent*	26.7		19.8	18.5	*2022*	12
2.56	College Tuition Spending-to-Income Ratio	*percent*	14.7		12.9	12.4	*2024*	9
2.56	Day Care Center and Preschool Spending-to-Income Ratio	*percent*	8.7		7.5	7.4	*2024*	9

2.56	Homeowner Spending-to-Income Ratio	*percent*	16.7	14.6	14.0	*2024*	9
2.53	Veterans Living Below Poverty Level	*percent*	9.7	7.4	7.2	*2019-2023*	2
2.41	Youth not in School or Working	*percent*	2.7	1.7	1.7	*2019-2023*	2
2.38	Adult Day Care Spending-to-Income Ratio	*percent*	13.4	11.3	12.3	*2024*	9
2.38	Home Renter Spending-to-Income Ratio	*percent*	19.3	16.8	17.7	*2024*	9
2.38	Student Loan Spending-to-Income Ratio	*percent*	5.5	4.8	4.7	*2024*	9
2.26	People 65+ Living Below 200% of Poverty Level	*percent*	31.9	28.4	28.1	*2023*	1
2.26	Residential Segregation - Black/White	*Score*	71.5	69.6		*2025*	10
2.21	Home Child Care Spending-to-Income Ratio	*percent*	3.8	3.3	3.4	*2024*	9
2.21	Income Inequality		0.5	0.5	0.5	*2019-2023*	2
2.21	Vocational, Technical, and Other School Tuition Spending-to-Income Ratio	*percent*	1.8	1.6	1.6	*2024*	9
2.18	Food Insecurity Rate	*percent*	15.1	14.1	13.5	*2022*	12
2.12	Adults with Disability Living in Poverty	*percent*	33.1	28.2	24.6	*2019-2023*	2
2.12	Households that Used Check Cashing, Cash Advance, or Title Loan Shops	*percent*	2.3	2.0	2.0	*2024*	8
2.12	Median Household Gross Rent	*dollars*	1,005	988	1,348	*2019-2023*	2
2.12	Mortgaged Owners Median Monthly Household Costs	*dollars*	1,529	1,472	1,902	*2019-2023*	2
2.03	Households Living Below Poverty Level	*percent*	16.7	14.0		*2022*	30

2.03	Utilities Spending-to-Income Ratio	*percent*	6.7		6.2	5.8	*2024*	9
2.00	Renters Spending 30% or More of Household Income on Rent	*percent*	47.5	25.5	45.1	50.4	*2019-2023*	2
1.97	Children Living Below 200% of Poverty Level	*percent*	42.8		38.3	36.1	*2023*	1
1.97	Families Living Below 200% of Poverty Level	*Percent*	25.6		22.8	22.3	*2023*	1
1.94	Children Living Below Poverty Level	*percent*	23.2		18.0	16.3	*2019-2023*	2
1.94	Families Living Below Poverty Level	*percent*	11.5		9.2	8.7	*2019-2023*	2
1.94	People 65+ Living Below Poverty Level (Count)	*people*	28,068				*2019-2023*	2
1.94	People Living Below Poverty Level	*percent*	16.2	8.0	13.2	12.4	*2019-2023*	2
1.88	Homeowner Vacancy Rate	*percent*	1.1		0.9	1.0	*2019-2023*	2
1.88	Households with Cash Public Assistance Income	*percent*	2.8		2.5	2.7	*2019-2023*	2
1.85	Health Insurance Spending-to-Income Ratio	*percent*	7.1		6.8	6.1	*2024*	9
1.85	Mortgaged Owners Spending 30% or More of Household Income on Housing	*percent*	25.2	25.5	21.2	28.5	*2023*	1
1.85	Severe Housing Problems	*percent*	15.7		12.7		*2017-2021*	10
1.82	Households that are Above the Asset Limited, Income Constrained, Employed (ALICE) Threshold	*percent*	58.0		61.0		*2022*	30
1.79	People Living Below 200% of Poverty Level	*percent*	32.2		29.6	28.2	*2023*	1
1.76	Young Children Living Below Poverty Level	*percent*	24.9		20.0	17.6	*2019-2023*	2

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

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

1.65	Healthy Policies Adopted by Designated Ohio Healthy Programs (Count)	*policies*	264				*2021*	11
1.59	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 Fairview Hospital Community described in the body of this CHNA report. All data are sourced from Claritas Pop-Facts® (2024 population estimates), unless otherwise noted.

Table 11: Population Size of Hospital Community by Zip Code

Zip Code	Population
44070	31,764
44102	41,880
44107	49,191
44109	37,444
44111	39,791
44116	21,278
44126	16,603
44129	27,801
44130	49,467
44134	37,610
44135	25,792
44142	18,043
44144	20,879
44145	33,573
Fairview Hospital Community (Total)	451,116

Table 12: Age Profile of Hospital Community and Surrounding Geographies

Age Category	Fairview Hospital Community	Cuyahoga County	Ohio
0-4	5.2%	5.2%	5.6%
5-9	5.2%	5.4%	5.7%
10-14	5.3%	5.6%	6.1%
15-17	3.3%	3.5%	3.8%
18-20	3.3%	3.9%	4.4%
21-24	4.3%	4.8%	5.3%
25-34	14.9%	13.5%	12.4%
35-44	13.8%	12.7%	12.2%
45-54	11.5%	11.2%	11.7%
55-64	13.2%	13.2%	13.0%
65-74	11.6%	12.1%	11.6%
75-84	5.9%	6.2%	6.1%
85+	2.4%	2.6%	2.2%
Median Age	41.5 years	41.4 years	40.5 years

Table 13: Racial/Ethnic Profile of Hospital Community and Surrounding Geographies

	Fairview Hospital Community	Cuyahoga County	Ohio	U.S.
White	73.1%	57.3%	75.7%	63.4%
Black/African American	9.0%	29.2%	12.8%	12.4%
American Indian/Alaskan Native	0.3%	0.2%	0.3%	0.9%
Asian	3.3%	3.6%	2.7%	5.8%
Native Hawaiian/Pacific Islander	0.0%	0.0%	0.1%	0.2%
Another Race	5.6%	3.1%	2.1%	6.6%
Two or More Races	8.7%	6.5%	6.4%	10.7%
Hispanic or Latino (any race)	13.0%	7.3%	5.0%	19.0%

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

Table 14: Population Age 5+ by Language Spoken at Home for Hospital Community and Surrounding Geographies

	Fairview Hospital Community	Cuyahoga County	Ohio	U.S.
Only English	84.0%	88.5%	92.8%	78.0%
Spanish	7.4%	4.3%	2.3%	13.4%
Asian/Pacific Islander Language	1.2%	1.5%	1.0%	3.5%
Indo-European Language	4.9%	4.3%	2.8%	3.8%
Other Language	2.5%	1.5%	1.1%	1.2%

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

Table 15: Household Income of Hospital Community and Surrounding Geographies

Income Category	Fairview Hospital Community	Cuyahoga County	Ohio
Under $15,000	10.1%	12.8%	9.5%
$15,000 - $24,999	8.9%	9.1%	7.8%
$25,000 - $34,999	9.1%	8.7%	8.0%
$35,000 - $49,999	13.5%	12.5%	12.2%
$50,000 - $74,999	18.2%	16.5%	17.0%
$75,000 - $99,999	13.2%	11.9%	13.0%
$100,000 - $124,999	9.0%	8.4%	9.9%
$125,000 - $149,999	5.8%	5.8%	7.0%
$150,000 - $199,999	5.9%	6.2%	7.2%
$200,000 - $249,999	2.8%	3.0%	3.5%
$250,000 - $499,999	2.5%	3.4%	3.4%
$500,000+	1.1%	1.7%	1.6%
Median Household Income	$62,740	$60,568	$68,488

Table 16: Poverty Rates in Hospital Community and Surrounding Geographies

	Families Below Poverty
Fairview Hospital Community	11.2%
Cuyahoga County	12.2%
Ohio	9.4%
U.S.	8.8%
Fairview Hospital Zip Codes	-
44070	7.0%
44102	25.7%
44107	8.4%
44109	21.0%
44111	16.8%
44116	2.9%
44126	6.3%
44129	7.7%
44130	7.4%
44134	6.1%
44135	19.6%
44142	6.5%
44144	11.5%
44145	4.8%

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

Table 17: Educational Attainment of Hospital Community and Surrounding Geographies

	Fairview Hospital Community	Cuyahoga County	Ohio	U.S.
Less than High School Graduate	10.4%	9.3%	8.6%	10.6%
High School Graduate	29.7%	27.2%	32.8%	26.2%
Some College, No Degree	20.5%	20.4%	19.6%	19.4%
Associate Degree	8.5%	8.3%	8.9%	8.8%
Bachelor's Degree	19.9%	20.4%	18.6%	21.3%
Master's, Doctorate, or Professional Degree	11.1%	14.4%	11.5%	13.7%

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

Table 18: High Rent Burden in Hospital Community and Surrounding Geographies

	Renters Spending 30% or More of Income on Rent
Cuyahoga County	47.5%
Ohio	45.1%
U.S.	50.4%
Fairview Hospital Zip Codes	-
44070	44.2%
44102	48.8%
44107	38.4%
44109	48.1%
44111	46.7%
44116	43.7%
44126	42.1%
44129	38.0%
44130	43.2%
44134	41.8%
44135	53.6%
44142	38.9%
44144	43.5%
44145	49.8%

All values: American Community Survey (2019-2023)

Table 19: Internet Access in Hospital Community and Surrounding Geographies

	Households with Internet
Cuyahoga County	87.5%
Ohio	89.0%
U.S.	89.9%
Fairview Hospital Zip Codes	-
44070	90.8%
44102	81.8%
44107	90.9%
44109	81.7%
44111	88.0%
44116	90.3%
44126	92.7%
44129	89.7%
44130	88.3%
44134	88.0%
44135	84.0%
44142	87.3%
44144	85.8%
44145	92.9%

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 Cuyahoga County. This scan involved a review of recent community health assessments, needs reports, and partner studies across healthcare, public health, and social service sectors. Findings from local efforts, including reports from the United Way, hospital systems, and regional health collaboratives, corroborated the relevance of the five prioritized needs in this 2025 CHNA process for Fairview Hospital.

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

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

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

[16] Ohio Department of Health. (2023). *Ohio State Health Assessment 2023*. Ohio University; Ohio Department of Health. Retrieved from Ohio Department of Health website.
[17] Cleveland Parks & Recreation Plan Team. (2024). *Community needs assessment report* [PDF]. City of Cleveland Department of Parks & Recreation. https://cleparksrecplan.com/wp-content/uploads/240102_Community-Needs-Assessment-Report_web.pdf
[18] 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
[19] Cuyahoga County Planning Commission. (December 2023). *Our County: The 2023 data book* [PDF]. Cuyahoga County Planning Commission. https://s3.countyplanning.us/wp-content/uploads/2023/12/Our-County-2023-reduced.pdf?
[20] Kent State University College of Public Health. (2024). *Greater Cleveland LGBTQ+ community needs assessment* [PDF]. The Greater Cleveland LGBTQ+ Community Needs Assessment Research Team. https://www.lgbtqohio.org/sites/default/files/docs/KSU-028_CommunityReport_102124_FA.pdf
[21] Cuyahoga County CHNA Steering Committee. (2022). *2022 Cuyahoga County community health needs assessment* [PDF]. Conduent Healthy Communities Institute & Cuyahoga County Community Partners. https://www.healthyneo.org/content/sites/cuyahoga/Resources/CHNA-Cuy-Cty-11.22.pdf
[22] Cuyahoga County Department of Health and Human Services, Division of Senior & Adult Services. (2023). *Livable Cuyahoga needs assessment report*. Cuyahoga County. Retrieved June 2025, from https://hhs.cuyahogacounty.gov/docs/default-source/default-document-library/reports/livable-cuyahoga-needs-assessment-report.pdf?sfvrsn=b1f65b31_1

Appendix D: Community Input Assessment Tools and Key Findings

Community Stakeholder Facilitation Guide

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

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

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

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

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

Section #1: Introduction

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

Section #2: Community Health Questions and Probes

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

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

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

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

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

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

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

- **How can we make sure that community voices are heard when decisions are made that affect their community?**
    - What would be the best way to communicate with community members about 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 19 organizations provided feedback for the Fairview Hospital community. Interviews with each stakeholder varied by individual and the amount of feedback they provided. They generally ranged from thirty to sixty minutes. A full write up of qualitative data findings and the community stakeholder facilitation guide can be found in Appendix D.

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

- ADAMHS Board of Cuyahoga County
- ASIA (Asian Services In Action)
- Benjamin Rose Institute on Aging
- Boys and Girls Clubs of Northeast Ohio
- City of Cleveland Department of Public Health
- City of Cleveland, Division of Fire
- Cleveland Clinic Children's
- Cuyahoga County Board of Health
- Cuyahoga Metropolitan Housing Authority
- Esperanza
- Fairview Park Schools
- First Year Cleveland
- Greater Cleveland Food Bank
- Lead Safe Cleveland Coalition
- LGBTQ+ Assessment Greater Cleveland / Cleveland Clinic
- NAMI Greater Cleveland
- Neighborhood Family Practice (FQHC)
- West Park CDC
- West Park YMCA

The following are summary findings for each of the five 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 Fairview Hospital serves. Participants identified multiple persistent barriers that continue to limit access to timely and affordable care, particularly for low-income populations, older adults, and communities of color. Transportation, affordability, and availability of culturally responsive care were among the most frequently mentioned challenges. Stakeholders emphasized that even individuals with health insurance often experience difficulty navigating the system or affording necessary prescriptions, follow-up care, or specialty services. Many stressed the importance of co-located or integrated services and the need for greater trust and

continuity in provider relationships, especially in historically under-resourced communities.

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

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

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

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

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

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

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

Community input reaffirmed that access to quality, affordable healthcare is a pressing and multifaceted issue for the Fairview Hospital community. Residents face compounding barriers, including cost, distance, limited provider availability, and lack of culturally informed services, which affect their ability to engage in preventive care and manage chronic conditions. For many communities, an absence of trust and continuity further exacerbates differences in health outcomes. These insights highlight the need for patient-centered strategies that integrate health and social services, prioritize cultural responsiveness, and remove logistical and financial barriers to care.

Behavioral Health: Mental Health and Substance Use

The following highlights key insights from stakeholder interviews regarding behavioral health in the community Fairview Hospital serves. Participants consistently identified mental health and substance use as pressing and pervasive concerns that impact residents across all age groups. These issues have intensified in recent years, driven by the lingering effects of the COVID-19 pandemic, social isolation, trauma, and ongoing economic instability. Stakeholders emphasized that behavioral health challenges are closely tied to broader community conditions, including housing insecurity, poverty, and lack of social support. Barriers to accessing behavioral health care, such as provider shortages, stigma, and limited culturally responsive services, remain significant and prevent many individuals from receiving timely or adequate care.

The following are highlights of participant feedback regarding behavioral health:

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

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

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

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

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

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

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

Chronic Disease Prevention & Management

The following highlights key insights from stakeholder interviews regarding chronic disease prevention and management in the community Fairview Hospital serves. Participants discussed multiple factors that contribute to the onset and progression of chronic diseases, including poor nutrition, limited access to preventive care, and challenges managing conditions like diabetes and heart disease. Stakeholders emphasized that addressing these conditions requires a holistic and community-based approach that integrates education, early detection, and accessible ongoing care. There was also a strong emphasis on the need for targeted interventions for older adults and under-resourced populations who face additional barriers to wellness.

Nutrition & Healthy Eating and Wellness & Lifestyle

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

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

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

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

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

Cancer
The following are highlights of participant feedback regarding cancer:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Maternal and Child Health

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

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

Maternal, Fetal & Infant Health

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

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

Children's Health

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

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

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

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

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

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

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

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

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

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

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

Health-Related Social Needs

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

Prevention & Safety

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

Quality of Life (Community, Economy, Education)

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

Community Infrastructure and Engagement

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

Economic Opportunity and Stability

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

Education as Foundation for Well-being

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

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

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

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

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

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

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

Appendix E: Impact Evaluation

Actions Taken Since Previous CHNA

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

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

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

Access to Affordable Healthcare

Actions and Highlighted Impacts:

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

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

C. Fairview Hospital partnered with Neighborhood Family Practice, a federally qualified health center (FQHC), to provide follow-up appointments and community referrals for patients discharged from Fairview Hospital Emergency Department. The pilot program was implemented to improve continuity of care, reduce gaps in treatment, and strengthen community health support.

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

Behavioral Health

Actions and Highlighted Impacts:

A. Through the Opioid Awareness Center, the hospital participated in the Northeast Ohio Hospital Opioid Consortium and Cuyahoga County Opiate Task Force, and community-based classes and presentations. Cleveland Clinic continued to provide preventative education and share evidence-based practices.

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

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

D. In collaboration with community partners and schools, the Fairview Hospital Adolescent Psychiatry team administered the *Transition Bridge Program*, which supported students transitioning from an inpatient mental health setting back to the community.

Chronic Disease Prevention and Management

Actions and Highlighted Impacts:

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

B. In collaboration with Taussig Cancer Center, Fairview Hospital provided free community mammogram and lung screenings.

C. Fairview Hospital partnered with Westown Physician Center and Medworks to host a Women's Health Clinic offering free healthcare services to women and children.

D. The Fairview Hospital Wellness Center provided classes focused on physical and emotional health. Class topics included child development, fall prevention, pregnancy and postpartum health, heart disease, arthritis, cognitive aging, diabetes, dementia, stroke awareness, and breast cancer prevention.

Maternal and Child Health

Actions and Highlighted Impacts:

A. Cleveland Clinic continued to participate in First Year Cleveland, the Cuyahoga County Infant Mortality Task Force to gather data, align programs, and coordinate a systemic approach to improving infant

mortality. Supported expanded evidence-based health education to expecting mothers and families.

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

C. The hospital continued to offer and expand capacity for Centering Pregnancy group prenatal care model to expecting mothers. In June 2024, Fairview Hospital implemented a TeamBirth model focused on improving communication to drive better health outcomes.

D. Fairview Hospital provided the Maternal and Infant Mortality Awareness and Prevention Program to encourage enrollment in supportive evidence-based programs.

E. Fairview Hospital partnered with Cuyahoga Metropolitan Housing Authority to host a *Community Baby Shower*. The hospital provided mothers and families with education, resources, and supplies to support maternal and infant well-being.

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

Health-Related Social Needs

Actions and Highlighted Impacts:

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

B. Fairview Hospital partnered with community-based organizations to host food drives and volunteer at food banks to improve access to healthy foods.

C. Fairview Hospital supported Kamm's Corners Farmers Market (KCFM), ensuring the market continues to thrive as a cornerstone of community engagement and healthy living.

D. Cleveland Clinic supported the Summer Meals Program, which ensures children and teens have access to nutritious meals during the summer

when schools no longer provide student meals. We partnered with over 100 local organizations to provide more than 200,000 meals to approximately 10,000 children across Northeast Ohio. This initiative is part of Cleveland Clinic's larger $10.4 million commitment to addressing food insecurity across our communities by helping families access the resources they need to thrive.

E. Fairview Hospital engaged students from multiple school districts and Upward Bound program in immersive on-site visits to expose students to various types of careers in healthcare. The Differential Diagnosis program provided students with the opportunity to learn the process of diagnosing and identifying medical problems, and Launchpad to Nursing Boot Camp, a community outreach program offered to middle and high school students an exploration of nursing opportunities through information and immersive learning.

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

Appendix F: Acknowledgements

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

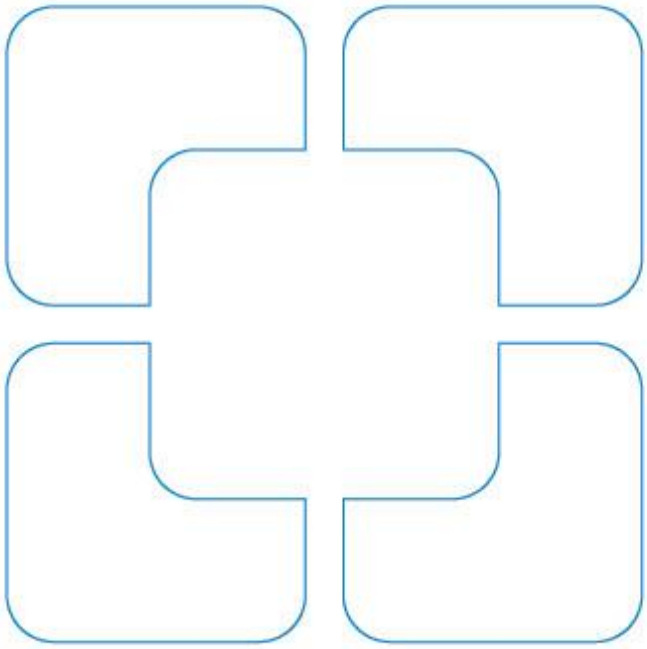
Authors for this report include:

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

Appendix G: City of Lakewood Community Health Needs Assessment

The most recent City of Lakewood CHNA is included as an appendix in the Cleveland Clinic Fairview Hospital 2025 CHNA, pursuant to the Master Agreement among the City of Lakewood, Lakewood Hospital Association, and the Cleveland Clinic dated December 21, 2015.

On September 9, 2022, the City of Lakewood, alongside its partners at the Healthy Lakewood Foundation, the Three Arches Foundation and the Center for Community Solutions released the Lakewood 2022 CHNA report. This report, the first of two reports tied to the Lakewood CHNA and Action Plan, comes after nearly a year of research and analysis conducted by Community Solutions. The report was built on primary data from the U.S. Census as well as secondary data tied to a broad, statistically representative community survey, numerous focus groups, and interviews with key stakeholders in the City of Lakewood. The report is organized around the Center for Disease Control's definitions for health-related social needs and documents key indicators of community health: economic stability, access to both quality education and healthcare, neighborhood and built environment, and social and community context. Included in the report is an infographic, an executive summary, a larger report, as well as an extensive appendix for public use. https://www.lakewoodoh.gov/accordions/chna-and-action-plan-documents-data/



clevelandclinic.org/**CHNAreports**

25-CCC-6446158

Cleveland Clinic
Fairview Hospital

Implementation Strategy Report

2025



FAIRVIEW HOSPITAL
2025 Community Health Needs Assessment
Implementation Strategy Report for Years 2026 – 2028

Table of Contents

Fairview Hospital Implementation Strategy Report 122

I. Introduction and Purpose 122
A. Description of Hospital 122

II. Fairview Hospital Community Definition 123

III. How Implementation Strategy was Developed 125

IV. Summary of the Community Health Needs Identified 125

V. Needs Hospital Will Address 125
A. Access to Healthcare 126
B. Behavioral Health 126
C. Chronic Disease Prevention and Management 127
D. Maternal and Child Health 128
E. Health-Related Social Needs 128

Fairview Hospital 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 Fairview 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 Fairview Hospital. This report includes strategies for years 2026 through 2028.

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

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

A. Description of Hospital

Fairview Hospital, a member of the Cleveland Clinic health system, is a 498-bed[23] acute-care teaching hospital located at the western edge of Cleveland, overlooking the Cleveland Metroparks. With more than 110 years of service to the community, Fairview Hospital offers a comprehensive range of medical services supported by clinical Centers of Excellence in heart care, cancer, birthing, surgery, emergency, and trauma services. The hospital is accredited by the Joint Commission and serves as a training site for residency programs in family medicine, general surgery, and internal medicine, with affiliations to multiple medical schools for student clerkships. Fairview also participates in advanced specialty training programs sponsored by Cleveland Clinic, including anesthesiology, pediatrics, radiology, and sports medicine. The hospital is nationally recognized for its leadership in blood conservation through its Center for Blood Conservation and serves as the first site for the Bloodless Medicine and Surgery Institute,

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

training clinicians worldwide in innovative approaches to blood management. Fairview Hospital continues to earn recognition for the quality of its care from national accrediting bodies, insurers, referring physicians, and the patients and families it serves.

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

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

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

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

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

II. Fairview Hospital Community Definition

The community definition describes the zip codes where approximately 75% of Fairview Hospital Emergency Department discharges originated in 2023. Figure 1 shows the specific geography for the Fairview Hospital 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: Fairview Hospital Community Definition

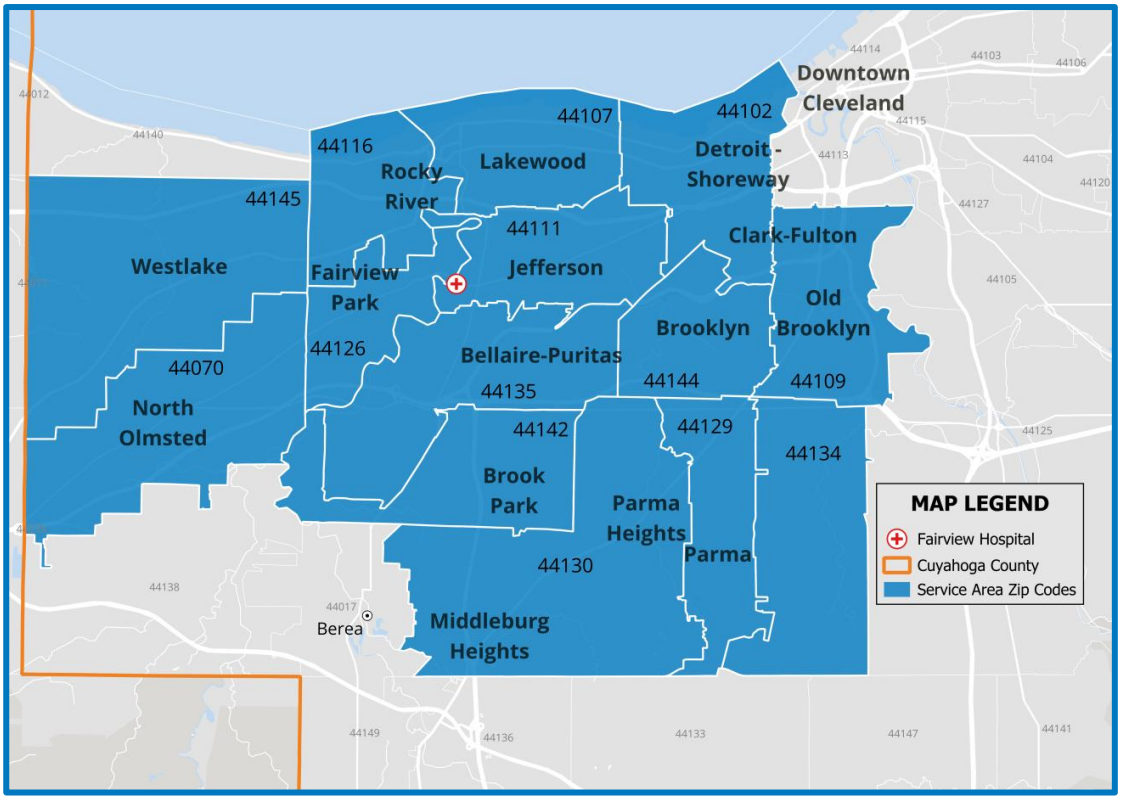


Table 1: Fairview Hospital Community Definition

Zip Code	Postal Name
44070	North Olmsted
44102	Detroit-Shoreway
44107	Lakewood
44109	Brooklyn-Centre
44111	Jefferson
44116	Rocky River
44126	Fairview Park
44129	Parma
44130	Middleburg Heights
44134	Parma
44135	Bellaire-Puritas
44142	Brook Park
44144	Brooklyn
44145	Westlake

III. How Implementation Strategy was Developed

This Implementation Strategy was developed by members of leadership at Fairview Hospital representing several departments of the organization, including clinical administration, medical operations, nursing, and community health. This team incorporated input from the hospital's community and local nonprofit organizations to prioritize selected strategies and determine possible collaborations. Leadership at the Fairview Hospital 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

Fairview Hospital's prioritized community health needs as determined by analyses of quantitative and qualitative data from the 2025 CHNA include:

- Access to Healthcare
- Behavioral Health
- Chronic Disease Prevention and Management
- Maternal and Child Health
- Health-Related Social Needs

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

V. Needs Hospital Will Address

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

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

The strategies included in this ISR reflect collaborative efforts between Fairview Hospital and local nonprofit, public health, and community-based organizations. These coordinated initiatives are intended to improve health outcomes within the community the hospital serves.

A. Access to Healthcare

Access to healthcare remains a significant challenge for the Fairview Hospital community, as identified in the 2025 CHNA. Despite existing infrastructure, barriers such as cost, transportation, technology, and mistrust hinder care, and contribute to ongoing differences in access across the community. Affordability issues, including high co-pays and limited prescription coverage, along with long wait times and a lack of integrated services further discourage people from seeking necessary care. Cultural and linguistic responsiveness is critical to building trust. Secondary and geospatial data show high rates of preventable hospitalizations and concentrated need in specific neighborhoods, underscoring urgent gaps in access for communities served by Fairview Hospital.

Access to Healthcare Initiatives for 2026-2028 include:

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

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

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

B. Initiative: Collaborate with Neighborhood Family Practice, a Federally Qualified Health Center (FQHC), community-based organizations, and local health department to provide access and continuum of healthcare services.

Anticipated Impacts: Improve healthcare access and connect individuals with community resources.

B. Behavioral Health

Behavioral health, encompassing mental health and substance use, emerged as a top priority in the Fairview Hospital 2025 CHNA due to widespread needs and service gaps. Depression, anxiety, and trauma are prevalent, worsened by social isolation, poverty, and housing instability, with COVID-19 amplifying these challenges. Workforce shortages, long wait times, stigma, and lack of culturally responsive care hinder access, especially for youth, older adults, and low-income populations. Substance misuse, notably opioids and fentanyl, remains severe, driving calls for low-barrier treatment, harm reduction, and trauma-informed care. Data show high rates of poor mental health, elevated drug

poisoning deaths, and a death rate due to suicide exceeding state and national benchmarks, underscoring urgent need for integrated, community-based strategies.

Behavioral Health Initiatives for 2026-2028 include:

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

A. **Initiative:** Collaborate with community-based organizations, schools, and local healthcare providers to educate and understand behavioral health issues, available resources, and treatment options for mental health and substance misuse issues.

   Anticipated Impacts: Increase awareness of treatment, reduce stigma, and improve early identification of behavioral health conditions.

C. Chronic Disease Prevention and Management

Chronic Disease Prevention and Management was identified as a key priority in the Fairview Hospital 2025 CHNA due to its high prevalence, preventability, and strong ties to social and economic conditions. Diseases such as diabetes, heart disease, cancer, and hypertension remain leading causes of death and disability, yet early detection and sustained care can significantly reduce risk. Barriers include affordability, fragmented care, long wait times, and limited navigation support, which discourage routine monitoring. Stakeholders emphasized culturally responsive education, community health workers, and integrated services addressing medical and social needs like nutrition and housing.

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

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

A. **Initiative:** Provide community health education and screenings regarding chronic diseases and conditions for community-based organizations, residents, and faith-based organizations.

   Anticipated Impacts: Address chronic disease issues of diabetes, heart disease, cancer, hypertension, chronic obstructive pulmonary disease, obesity. Improve screening follow-up rates and therefore reduce behavioral risk factors.

B. **Initiative:** Through the hospital's Wellness Center, provide classes focused on physical and emotional health, and offer resources to address health-related social needs.

   Anticipated Impacts: Increase physical activity and nutritional education, improve access to social services and assistance programs.

D. Maternal and Child Health

Maternal and Child Health was identified as a top priority in the Fairview Hospital 2025 CHNA due to its strong influence on long-term health and community wellbeing. Persistent gaps in maternal and infant outcomes are linked to poverty, housing instability, limited insurance, and unequal access to quality obstetric and pediatric care. Barriers include lack of nearby birthing facilities, transportation challenges, and provider shortages, while chronic conditions and mental health concerns heighten risks during pregnancy. Stakeholders emphasized culturally grounded supports such as doulas, home visiting, and integrated behavioral health. Children's health concerns include rising behavioral issues, limited school-based services, and unsafe environments. Data reveal high rates of preterm births, infant mortality, and child mortality.

Maternal and Child Health Initiatives for 2026-2028 include:

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

A. **Initiative:** Continue Cleveland Clinic services of Community Health Workers and/or the co-location of community organizations with hospital facilities, providing assistance for families from pregnancy throughout baby's first year of life.

   Anticipated Impacts: Ensure connection to obstetric/pediatric medical services, improve health and birth outcomes for pregnant patients, and support families with community resources.

B. **Initiative:** Co-Design strategies with community-based organizations to connect mothers with essential resources.

   Anticipated Impacts: Gather data, align programs, and coordinate a systemic approach to improving infant mortality in communities, increase the number of babies that reach their first birthday, improve health and well-being of mother and baby.

E. Health-Related Social Needs

Health-related social needs were identified as a critical priority in the Fairview Hospital 2025 CHNA due to their pervasive influence on health outcomes across all domains. Factors such as income, education, housing stability, transportation, digital access, and neighborhood safety significantly shape access to care and overall wellbeing. Stakeholders highlighted poverty, economic insecurity, and unsafe environments as major drivers of chronic stress and poor health, compounded by limited job opportunities and unaffordable housing. Education and school-based supports were emphasized as essential for long-term health improvement. Data confirm high concern in economy and education indicators, elevated violent crime and homicide rates, and

concentrated poverty. These findings underscore the need for coordinated upstream solutions to address systemic barriers.

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

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

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

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

B. **Initiative:** Expand a multi-pronged strategy to address food security through education and healthy food access options. Support key partnerships with Kamm's Corners Farmers Market and Greater Cleveland Food Bank.

   Anticipated Impacts: Improve self-efficacy associated with healthy eating, improve nutrition education, reduce childhood hunger.

C. **Initiative:** Strengthen the hospital's Community Advisory Council with continued integration of community voice and aligned strategic planning.

   Anticipated Impacts: Increase collaboration with community-based organizations, develop sustainable initiatives. Improve community awareness of available resources, develop a resource guide, and improve access to social supports.

D. **Initiative:** Continue the hospital's Differential Diagnosis Program, educating area students from John Hay High School and other Cleveland Metropolitan School District facilities, supporting workforce development in healthcare.

   Anticipated Impacts: Improve local employment opportunities, improve poverty rates.

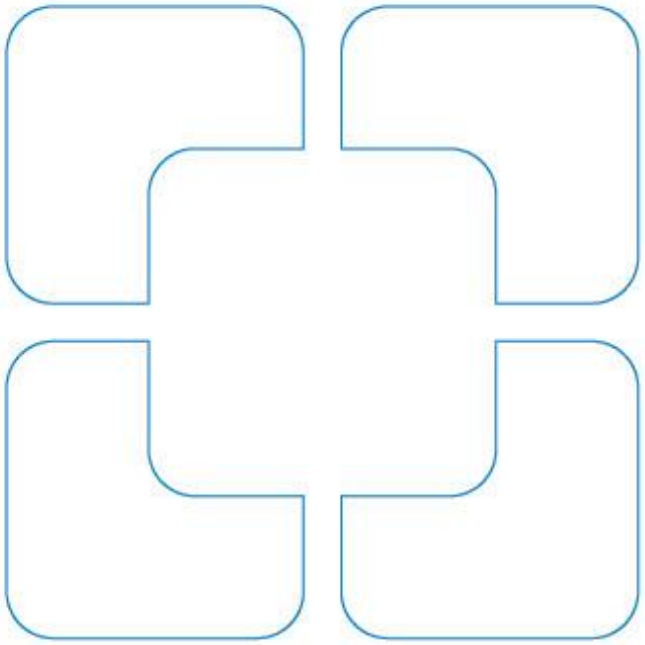
E. **Initiative:** In partnership with local and state stakeholders identify and treat children and families impacted by lead poisoning and identify risk factors. Expand initiative to include child daycare centers in City of Cleveland.

   Anticipated Impacts: Reduce lead poisoning, improve health outcomes for children exposed to lead within City of Cleveland.

While this ISR outlines specific strategies and programs identified to address the 2025 CHNA prioritized areas of Access to Healthcare, Behavioral Health, Chronic Disease Prevention and Management, Maternal and Child Health, and Health-Related Social Needs,

it does not reflect all the work being done by Fairview Hospital 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 Fairview Hospital to build stronger community collaborations and make smarter, more targeted investments to improve the health of the people in the communities they serve.

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



clevelandclinic.org/**CHNAreports**

25-CCC-6446244