Cleveland Clinic
Lutheran Hospital

Community Health Needs Assessment

2025

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Lutheran Hospital 2025 Community Health Needs Assessment

Introduction

Lutheran Hospital, a member of the Cleveland Clinic health system, is a 192 staffed-bed[1] acute-care facility located in the Ohio City neighborhood near downtown Cleveland, Ohio. The hospital is recognized for its clinical excellence in several specialized areas, including spine and orthopedic surgery, behavioral health, and chronic wound care. Lutheran Hospital serves as a trusted healthcare provider for residents of Cleveland and surrounding communities, offering safe, high-quality care delivered by a skilled and compassionate team of healthcare professionals.

As part of the broader Cleveland Clinic health system, Lutheran 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 Lutheran, contributes to the system-wide advancement of clinical research and medical innovation. Patients at Lutheran Hospital benefit from access to novel treatments, clinical trials, and evidence-based practices developed and shared across the Cleveland Clinic network.

Lutheran 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 and reduction of barriers. It has received national recognition for excellence in patient safety and care quality, and remains committed to treating every patient with kindness, dignity, and respect.

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

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

Lutheran 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/lutheran-hospital.

CHNA Background

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

Lutheran Hospital Community Definition

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



Table 1: Lutheran Hospital Community Definition

Zip Code	Neighborhood
44102	Detroit Shoreway
44105	South Broadway
44109	Brooklyn-Centre
44111	Jefferson
44113	Tremont
44114	Downtown Cleveland
44115	Industrial Valley
44135	Bellaire-Puritas
44144	Brooklyn

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 9-zip-code Lutheran 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 United Way, hospital systems, and regional health collaboratives—corroborated the relevance of the five prioritized needs prioritized in this 2025 CHNA process for Lutheran 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 exist among communities; and health-related social needs, particularly poverty, housing insecurity, and gun violence, impact all other areas of health.

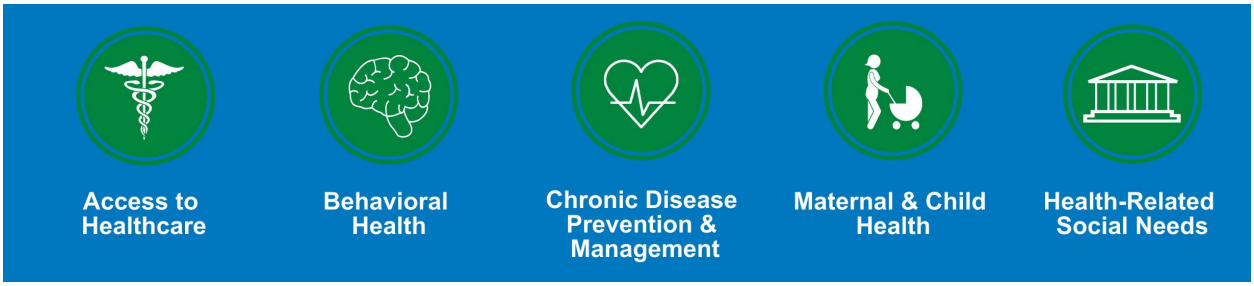
Primary Data Methodology and Key Findings

To ensure community priorities and lived experience were centered in this assessment, conversations with community stakeholders were conducted across the Lutheran Hospital community. These conversations included individuals from 18 organizations who spoke directly to the needs within the Lutheran 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 prenatal care that is culturally aware. Financial hardship was described as a root cause affecting every other health domain. Stakeholders called for expanded prevention, investment in community infrastructure, and systems-level changes that address the underlying conditions shaping health across generations.

Summary

2025 Prioritized Health Needs

Lutheran 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 differences in health outcomes and improve health outcomes for all populations in the community served by Lutheran Hospital.

The five prioritized community health needs identified in this 2025 Lutheran 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

Key Themes from Community Input

- ·Geographic and Transportation Barriers
- Availability of Culturally Competent Care
- Insurance and affordability challenges
- Need for integrated services
- Trust and continuity of care

Warning Indicators

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

Access to Healthcare remains a critical and persistent priority for the Lutheran Hospital community, as affirmed by both primary and secondary data sources in this 2025 CHNA. It was identified again as a prioritized health need due to longstanding structural and systemic challenges that continue to limit equal access to care. When individuals can obtain timely, affordable, and culturally appropriate services, they are more likely to manage chronic conditions, prevent disease, and live healthier lives. Conversely, barriers to care contribute to differences in health outcomes, reliance on emergency care, and avoidable hospitalizations, placing strain on individuals, families, and the broader healthcare system.

Stakeholders consistently emphasized affordability, insurance gaps, transportation challenges, and limited culturally responsive care as primary barriers. These issues are compounded by fragmented service delivery and systemic differences that contribute to mistrust in the healthcare system. Residents often face high out-of-pocket costs for prescriptions, follow-up visits, and co-pays, while transportation barriers and complex scheduling discourage consistent care. Convenience was noted as a decisive factor, with many residents forgoing appointments when access was perceived as burdensome or time intensive.

Participants also underscored the importance of integrating healthcare with broader social needs such as housing, food access, and behavioral health services. Technological limitations further complicate navigation of telehealth and appointment systems, especially for lower-income residents. Finally, continuity of care and cultural awareness and community-based approaches were viewed as essential to strengthening trust and encouraging long-term engagement with providers. Without addressing these barriers, equal access to healthcare will remain out of reach for many residents in the Lutheran Hospital community.

Secondary indicators from trusted national and state data sources reinforce and provide further contextualization of the insights provided by community stakeholders. Several key indicators within the Healthcare Access category revealed concerning trends. On average, county residents spend 7.1% of their income on health insurance. This is higher than the national average of 6.1%. For Black residents in the county, this cost burden is even higher, at 8.8% of their income. Additionally, the adult insured rate in Cuyahoga County is just 72.1%, placing it in the lowest quartile for the state of Ohio.

Geospatial data from Conduent HCI's Community Health Index (CHI) further underscores the magnitude of access challenges. The CHI estimates health risk based on health-related social needs to estimate preventable hospitalizations and poor health outcomes on a scale from 0 to 100. All zip codes within the Lutheran Hospital community received an index score above 75, indicating elevated community health risks across the entire region. Notably, the 44115 zip code (Industrial Valley) had the region's highest CHI score at 99.9. 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 Lutheran 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

Behavioral Health: Mental Health & Substance Use Disorder

Key Themes from Community Input

- Access to Mental Health Services
- Stigma and Community Perception
- Integrated and School-Based Mental Health Supports
- Fentanyl and Opioid Crisis
- Need for Harm Reduction and Treatment Services
- Community-Based Prevention and Education

Warning Indicators

- Self-Reported General Health Assessment: Good or Better
- Poor Mental Health: Average Number of Days
- Poor Mental Health:14+ Days
- Adults who Feel Life is Slipping Out of Control
- Alcohol-Impaired Driving Deaths
- Age-Adjusted Drug and Opioid-Involved Overdose Death Rate
- Death Rate due to Drug Poisoning
- Adults who Binge Drink
- Adults who Drink Excessively
- Cigarette Spending-to-Income Ratio

In the Lutheran Hospital 2025 CHNA, Behavioral Health, including both mental health and substance use disorder, was identified as a top priority due to its widespread impact and the persistent gaps in prevention, treatment, and recovery services across the community. Stakeholders emphasized the urgency of addressing rising youth suicide rates, fentanyl-related overdoses, and pervasive stigma that discourages individuals from seeking care. Behavioral health was described as inseparable from overall health and community wellbeing, with stakeholders calling for more equal access to services and expanded resources to meet growing demand.
Community feedback pointed to a severe shortage of behavioral health providers, long wait times for appointments, and prohibitive costs that make care difficult to access, particularly for youth, older adults, and low-income residents. Participants noted that services are fragmented and difficult to navigate, with limited coordination across systems of care. They emphasized the importance of cultural awareness and linguistically accessible services. Stigma and fear of judgment were cited as major deterrents, compounded by generational differences in openness to discussing mental health.

Stakeholders also stressed the importance of expanding community-based approaches such as embedding mental health services in schools, housing developments, and trusted neighborhood organizations to promote early intervention and reduce barriers to care. They also highlighted the urgent need for low-barrier substance use treatment options and harm reduction strategies, including peer-to-peer supports and recovery navigation services. Many participants expressed that behavioral health challenges are closely tied to social and economic stressors such as unemployment, housing instability, and exposure to violence, underscoring the need for integrated approaches that address both clinical and health-related social needs. Without timely, affordable, and culturally responsive behavioral health services, residents will continue to face preventable crises with long-term impacts on individuals, families, and the broader community.

Secondary data findings reflect and support the urgency expressed by stakeholders. Within Cuyahoga County, mental health challenges are common. The average resident reports 6.0 mentally unhealthy days in the past 30 days—placing the county in the highest quartile nationwide. 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 average (16%). This is especially significant for the Lutheran Hospital community, where the proportion of American Indian/Alaska Native residents is more than twice the county average (0.53% vs. 0.24%).

Geographic analysis using Conduent HCI's Mental Health Index (MHI)—which assesses mental health risk based on local health-related social need—demonstrates a high burden of behavioral health needs across the Lutheran Hospital community. All zip codes scored above 90 on the MHI scale, indicating severe challenges throughout the community. The 44105 ZIP code (South Broadway) had the highest index score (99.7), highlighting a concentrated area of behavioral health need.

Substance use disorder data further underscore the community burden. Cuyahoga County's drug poisoning death rate (45.5 per 100,000) exceeds both the Ohio average (44.7) and the national rate (27.2) 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 use disorder within the Lutheran 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 Lutheran Hospital 2025 CHNA due to its high prevalence, disproportionate burden on certain populations, and strong connection to lifestyle, environmental, and other health-related social needs. Chronic 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, consistent care, and supportive environments. Stakeholders reinforced that chronic disease management is central to improving population health, reducing premature mortality, and alleviating the long-term economic and social costs associated with untreated conditions.

Community input emphasized barriers that limit effective prevention and management, including lack of access to affordable healthy foods, inadequate opportunities for physical activity, and the difficulty of maintaining care for individuals without stable housing, employment, or transportation. Informants noted that health behaviors are heavily shaped by structural barriers, such as neighborhood safety, environmental exposures, and poverty, which increase risk factors and limit residents' ability to prioritize wellness. In addition, many residents delay seeking care due to cost concerns, lack of insurance, or long wait times, leading to late diagnoses and more advanced disease progression.

Stakeholders also underscored the importance of culturally aware, community-based approaches to prevention and management. They called for greater investment in education and outreach, especially around nutrition, cancer screening, and cardiovascular health, tailored to meet the needs of diverse populations. Several emphasized the potential of co-located services, community health workers, and trusted neighborhood hubs to bridge gaps in care and support residents in navigating complex

health systems. Chronic disease was described as not only a medical issue but also a reflection of broader social needs, underscoring the importance of integrated strategies that combine clinical care with interventions addressing food access, safe environments, and economic opportunity.

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 that community-level barriers, such as limited access to healthy and affordable food, and inadequate recreational infrastructure, significantly contribute to the local burden of chronic disease. Participants described gaps in the food assistance system, particularly for individuals navigating programs that prioritize institutions over direct aid. Respondents also called attention to the need for early nutrition education for children and expressed support for community-based recreational programming as a means of supporting healthy lifestyles and preventing obesity, diabetes, and cardiovascular disease.

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. County residents are more likely to rely on fast food and less likely to cook at home compared to state and national averages, patterns linked to chronic disease risk. Conduent HCI's Food Insecurity Index (FII) showed that nearly all zip codes in the Lutheran Hospital community scored above 75, with ZIP code 44115 scoring 99.9, the highest in the region. These findings suggest that food hardship and poor nutrition are deeply embedded within broader social and economic conditions that shape wellness.

Cancer
Cancer was most frequently discussed by stakeholders in relation to early detection and access to screenings. Participants expressed concern that preventive services such as mammograms and cervical cancer screenings remain inaccessible to many, especially immigrant and refugee communities. Health fairs and community events were described as valuable opportunities for outreach and screening, particularly when trust and cultural relevance are prioritized.

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
Diabetes, hypertension, and stroke emerged frequently in stakeholder interviews as leading concerns. Participants emphasized the importance of early detection, continuity of care, and support for behavior change. They also highlighted the impact of environmental and social drivers, such as access to nutritious food and safe spaces for physical activity. These differences were repeatedly cited as contributing factors to differences in chronic disease outcomes.

Secondary data reinforce these concerns. Diabetes affects 9.9% of adults in Cuyahoga County, about 1 in 10. Kidney disease, often a complication of unmanaged diabetes, has an age-adjusted death rate of 18.0 per 100,000, placing the county among the highest quartile in Ohio. Data from Medicare recipients reveal disproportionately high rates of diabetes among Black/African American, Hispanic/Latino, and Asian American/Pacific Islander populations. Medicare data also indicate that the county's Black/African American population experiences a higher rate of chronic kidney disease than the general population (30% vs. 20% of Medicare recipients).

Heart disease and stroke are also prevalent. 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). Among Medicare recipients, Black residents are more likely to have hypertension (74% vs. 66% overall), and American Indian/Alaska Native residents are more likely to experience ischemic heart disease (27% vs. 21%).

Older Adult Health
Stakeholder feedback emphasized that older adults face distinct challenges in managing chronic conditions, including limited mobility, social isolation, stigma around mental and cognitive health, and barriers to accessing follow-up care. Home modifications and informal caregiving were seen as critical supports, while dementia and cognitive decline were described as increasingly urgent but often overlooked health issues.

Secondary data ranked Older Adult Health as the fourth highest scoring health need (score: 1.60). Over one-third of Cuyahoga County adults aged 65+ live alone (36.1%), and 12.3% live below the federal poverty level—both figures exceeding national rates. These factors, combined with transportation and care coordination barriers, place older adults at elevated risk for unmanaged chronic illness.

Adult day care was identified as a potential solution, but cost is a significant barrier. On average, adult day care in Cuyahoga County consumes 13.4% of household income, with the burden rising to 18.6% for Black households and 24.3% for Hispanic/Latino households.

Prioritized Health Need #4: Maternal and Child Health

Maternal & Child Health

Key Themes from Community Input

- High Rates of Infant Mortality and Maternal Health Differences in Health Outcomes
- Limited Access to Prenatal and Birthing Services
- Culturally Centered and Community-Based Maternal Support
- Systemic Gaps and Lack of Pediatric Providers
- Early Education and Healthy Lifestyle Promotion
- Mental Health Needs and Behavioral Supports for Children
- Impact of Environment and Social Stress
- Lead Exposure and Environmental Health

Warning Indicators

- Child Food Insecurity Rate
- Babies with Low Birthweight
- Child Mortality Rate: Under 20
- Teen Birth Rate: 15-17
- Home Child Care Spending-to-Income Ratio
- Preterm Births
- Infant Mortality Rate
- Gestational Hypertension
- Pre-Pregnancy Diabetes

In the Lutheran 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 are often symptoms of deeper systemic issues such as poverty, institutional barriers, environmental risk, and inequitable access to high-quality care.

Stakeholders expressed urgent concern about both maternal and child health outcomes in the Lutheran Hospital community, particularly among families with limited resources. Infant mortality was repeatedly cited as a critical issue, linked to maternal chronic conditions such as hypertension, diabetes, and obesity, as well as to inadequate prenatal care. Several participants underscored the geographic challenges of care, particularly the absence of birthing facilities in some communities, which has forced some mothers to rely on emergency transport during labor. These barriers are compounded by a shortage of pediatricians and obstetric providers, fragmented systems of support, and the financial burden of prenatal and pediatric care. Respondents also noted that differences in health outcomes, institutional mistrust, and stressors tied to poverty and housing instability contribute significantly to poor maternal and child health outcomes.

Community-based and culturally grounded programs were praised for addressing both medical and social needs by providing holistic care during pregnancy, delivery, and postpartum recovery. Stakeholders emphasized that such programs build trust, create supportive environments, and help mitigate barriers by centering the lived experiences of women.

Children's health also emerged as a pressing concern, with respondents highlighting the importance of early childhood education, healthy nutrition, and opportunities for safe physical activity. Gaps in behavioral health care for children, especially those in therapeutic or special education settings, were identified as urgent needs, alongside the effects of chronic stress, community violence, and housing instability on development. Lead exposure in older housing stock was cited as an ongoing threat to healthy growth and cognitive outcomes, reinforcing the need for coordinated, cross-sector solutions.

Secondary data findings for the community further affirm the significance of Maternal and Child Health challenges. This topic is divided into two subdomains: Children's Health (ranked third highest for the community with a secondary data analysis score of 1.65) and Maternal, Fetal, and Infant Health (ranked eighth, with a secondary data score of 1.51). Cuyahoga County's infant mortality rate (7.7 deaths per 1,000 live births) exceeds the state average (6.7), as do 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. The county's teen birth rate (7.3 per 1,000 females aged 15–17), while improving, remains high relative to many other counties in Ohio.

Differences in preterm birth rates offer further insight into the differences in birth outcomes across groups. Preterm births occur at higher rates in Cuyahoga than in Ohio overall (12.0% vs. 10.8%), and the rate among Black birthing individuals is especially elevated at 14.8%. Given the strong association between preterm birth and infant mortality, these figures raise serious concerns, particularly within the communities served by Lutheran Hospital.

Children's health outcomes in the secondary data analysis also reflect broader systemic challenges. The mortality rate for individuals under 20 years of age in Cuyahoga County stands at 70.8 deaths per 100,000. This is among the highest in the state of Ohio. Indicators such as Disconnection from School or Work Among Youth (2.7%) and high rates of violent crime suggest that social and economic drivers like safety, education, and overall opportunity are deeply intertwined with pediatric health. Environmental exposures further exacerbate risks: more than 15.9% 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

Health-Related Social Needs

Key Themes from Community Input

- Poverty as a Root Cause of Health and Safety Issues
- Violence, Crime, and Lack of Safety
- Affordable Housing and Infrastructure Gaps
- Employment, Wages, and Economic Mobility
- Economic Opportunity and Stability
- Education as a Tool for Safety and Empowerment
- Education as Foundation for Well-being
- Need for Upstream Investment in Prevention
- Community Infrastructure and Engagement

Warning Indicators

- Age-Adjusted Death Rate due to Firearms
- Death Rate due to Drug Poisoning
- Death Rate due to Injuries
- Severe Housing Problems
- Age-Adjusted Death Rate due to Unintentional Poisonings
- People 65+ Living Alone
- Median Monthly Owner Costs for Households without a Mortgage
- College Tuition Spending-to-Income Ratio
- Day Care Center and Preschool Spending-to-Income Ratio
- Homeowner Spending-to-Income Ratio
- Youth not in School or Working
- Children in Single-Parent Households
- Student Loan Spending-to-Income Ratio
- Residential Segregation - Black/White
- Social Associations

In the 2025 CHNA for Lutheran 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, neighborhood safety, and digital access shape individuals' ability to engage in healthy behaviors, access care, and manage chronic stress. These structural influences are strongly associated with differences in disease burden, life expectancy, and overall quality of life.

Community stakeholder feedback emphasized the deeply interconnected nature of poverty, violence, housing instability, and limited economic opportunity in the community served by Lutheran Hospital. Poverty was consistently described as a foundational driver of poor outcomes, influencing food insecurity, exposure to stress, and vulnerability to chronic illness. Safety also emerged as a pressing concern, with residents reporting daily exposure to gun violence, unsafe neighborhoods, and a lack of secure spaces for children and families. Housing insecurity, inadequate rental conditions, and environmental risks such as lead exposure were cited as ongoing threats to health and development. Stakeholders further noted gaps in digital connectivity and transportation, both of which limit access to employment, education, and health services.

Despite these barriers, participants highlighted community assets and opportunities for "upstream" investment. Schools, faith-based organizations, and local nonprofits were

seen as trusted institutions that could be leveraged to support stronger neighborhood networks, economic mobility, and social connection. Stakeholders recommended strategies such as early childhood education, job training programs tied to health system employment pipelines, and coordinated neighborhood development initiatives. Education was frequently described as a protective factor and a preventive strategy that fosters resilience, civic engagement, and long-term health. Stakeholders stressed that sustained investment in these upstream solutions, alongside direct service delivery, is essential to breaking cycles of poverty, improving safety, and creating equal opportunities for health.

Secondary data findings further validate the concerns raised by community stakeholders. Indicators across the areas of prevention and safety, education, economy, and community ranked among the highest areas of concern in Cuyahoga County. Notably, the topics Economy (score: 1.90) and Education (score: 1.72) received higher, more concerning scores, than nearly all health topics in Cuyahoga County. This indicates greater opportunities for improvement and positive impact within these areas in the Lutheran Hospital community.

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

Economic hardship is another defining feature of the Lutheran Hospital community. More than one in five households (22.3%) in the community live below the federal poverty level. This is more than twice the statewide rate (9.3%) and higher than the Cuyahoga County average (12.0%). The costs of basic needs, such as housing (19.3% of household income for renters), health insurance (7.1% of income), adult day care (13.4% of income), and early education (8.7% of income), outpace 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 Lutheran 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-based, needs-based approaches to improve health outcomes. The following sections provide an overview of the demographic characteristics and social needs influencing health in the Lutheran 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 Lutheran 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 Lutheran Hospital Community

According to the 2024 Claritas Pop-Facts® population estimates, the Lutheran Hospital community has an estimated population of 237,033 persons. The median age in the community is 37.7 years, which is younger than that of Ohio (40.3 years). Nearly a third of individuals are between 25-44 years old (31.8%).

About half the population are White (49.0%), which is a smaller percentage than that of the Ohio population (75.7%). About a quarter of the population are Black or African American (26.6%), and about a fifth are Hispanic or Latino (20.5%).

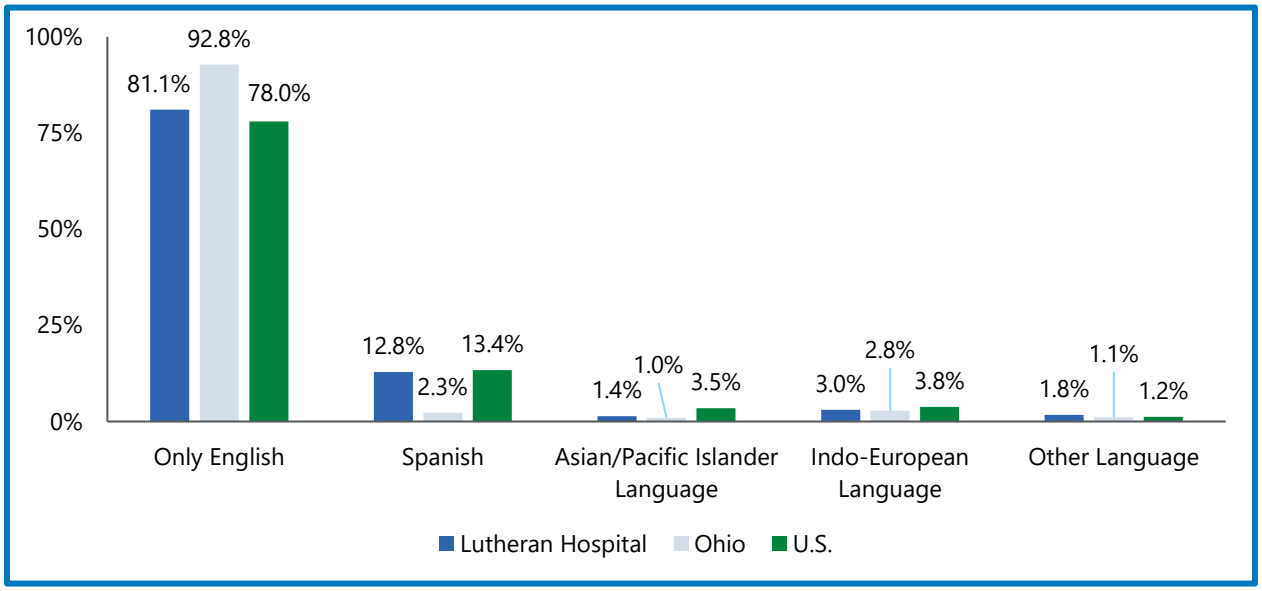
Among those aged five and above, nearly one in five (18.9%) speak a language other than English at home, including 12.8% who speak Spanish in the Lutheran Hospital Community (Figure 2). Understanding countries of origin and language spoken at home can help inform the cultural and linguistic context for the health and public health

[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

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 Lutheran Hospital Community is $45,075, which is lower than the median income for Ohio ($68,488) as well as the surrounding county of Cuyahoga ($63,671).

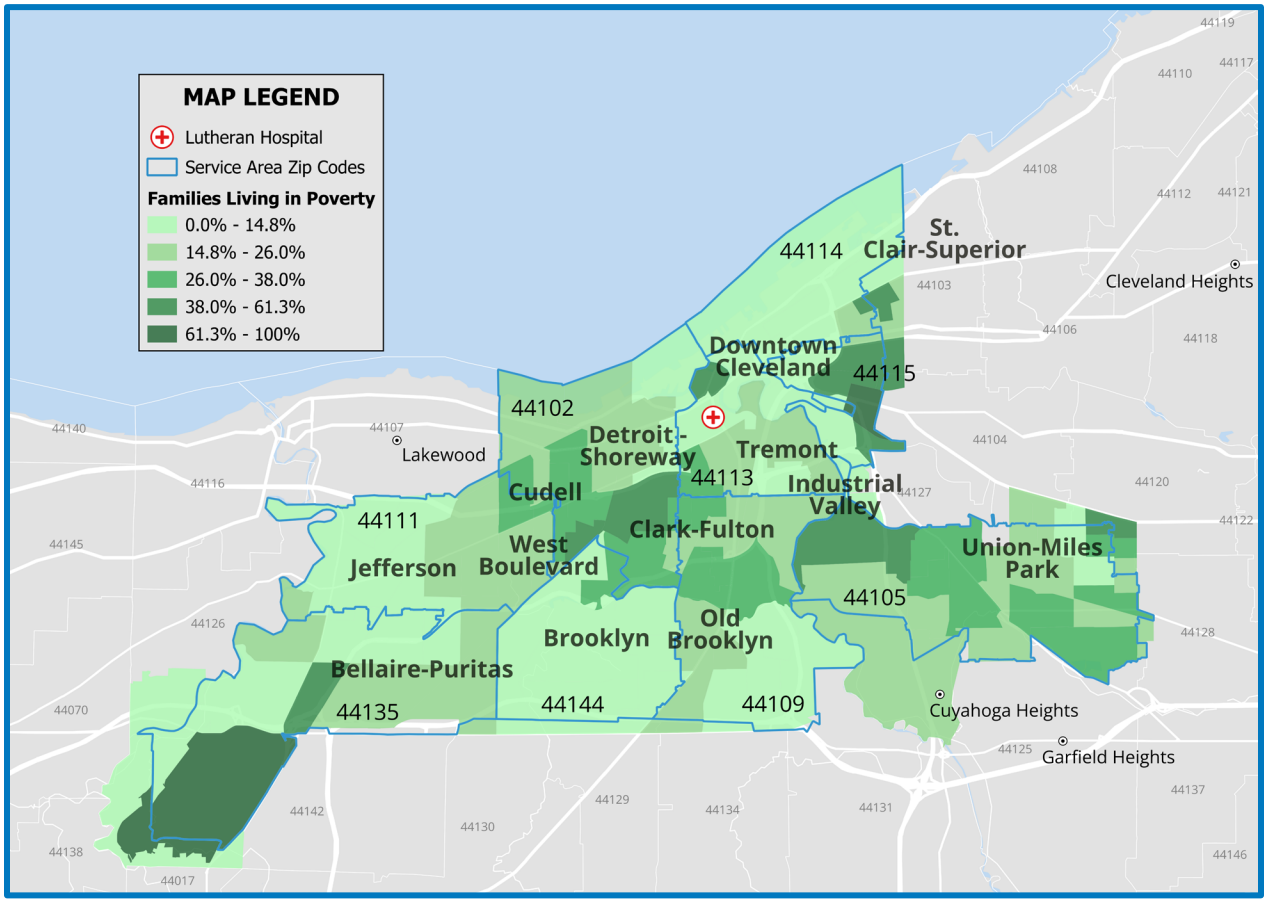
Federal poverty thresholds are set every year by the Census Bureau and vary by size of family and ages of family members. Overall, 21.9% of families in the Lutheran Hospital Community live below the poverty level, which is more than twice the state value (9.4%) and also substantially higher than the Cuyahoga County rate (12.2%). Within the Lutheran Hospital community, poverty is most concentrated in the Zip code 44115 (Industrial Valley) where more than half of families (58.5%) 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]

The color gradient illustrated in the maps provided offers additional insight at the census tract level, allowing for a more nuanced understanding of geographic variation. Examining neighborhood-level data is particularly valuable, especially in more densely populated zip codes, where broader data may obscure important local differences or trends. The following maps provide distinct differences at the census tract level.

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



Claritas Pop-Facts® (2024 population estimates)

Education and Employment

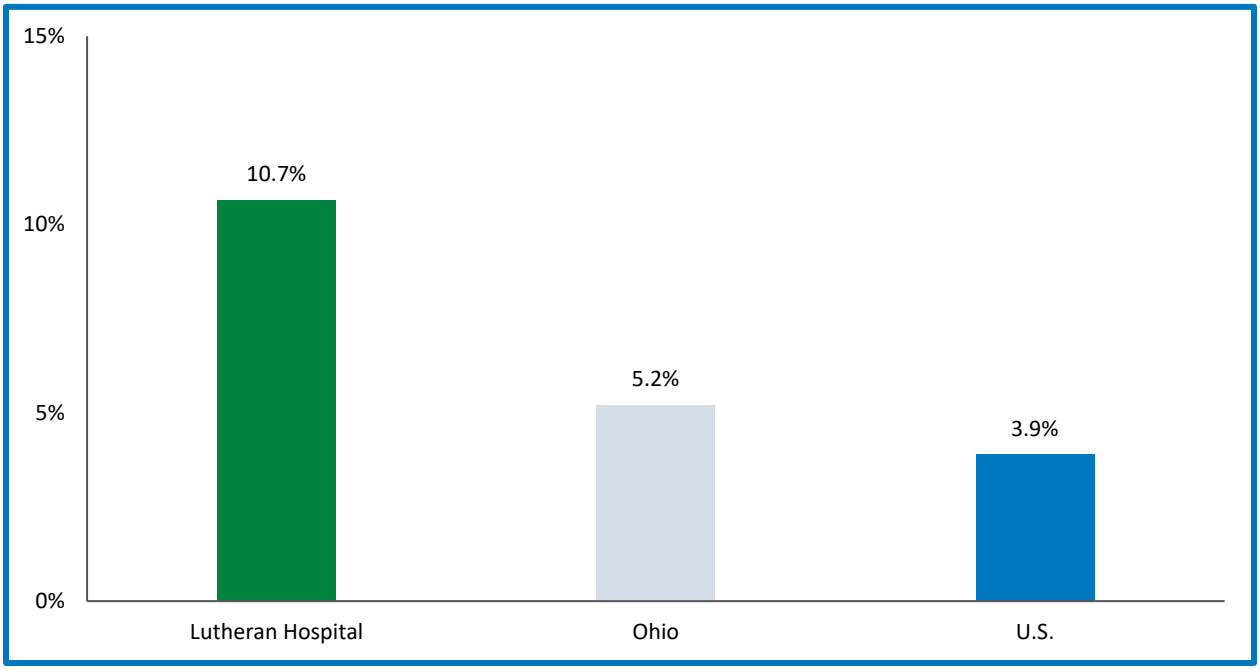
The majority of the population within the Lutheran Hospital community have a high school degree or higher (83.4%). However, this rate is lower than the surrounding Cuyahoga County population (90.7%) and the overall Ohio population (91.4%). Less than a quarter of the Lutheran Hospital community has a bachelor's degree or higher (22.7%),

[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

which is lower than both the Cuyahoga and Ohio populations (34.9% and 30.2%, respectively).

As seen in Figure 4, Ohio broadly has higher levels of unemployment than the U.S. (5.2% vs. 3.9%). The Lutheran Hospital community has an unemployment rate that is about twice that of the Ohio rate (10.7%). This population also has a larger unemployment rate than the surrounding Cuyahoga County population (7.3%).

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]

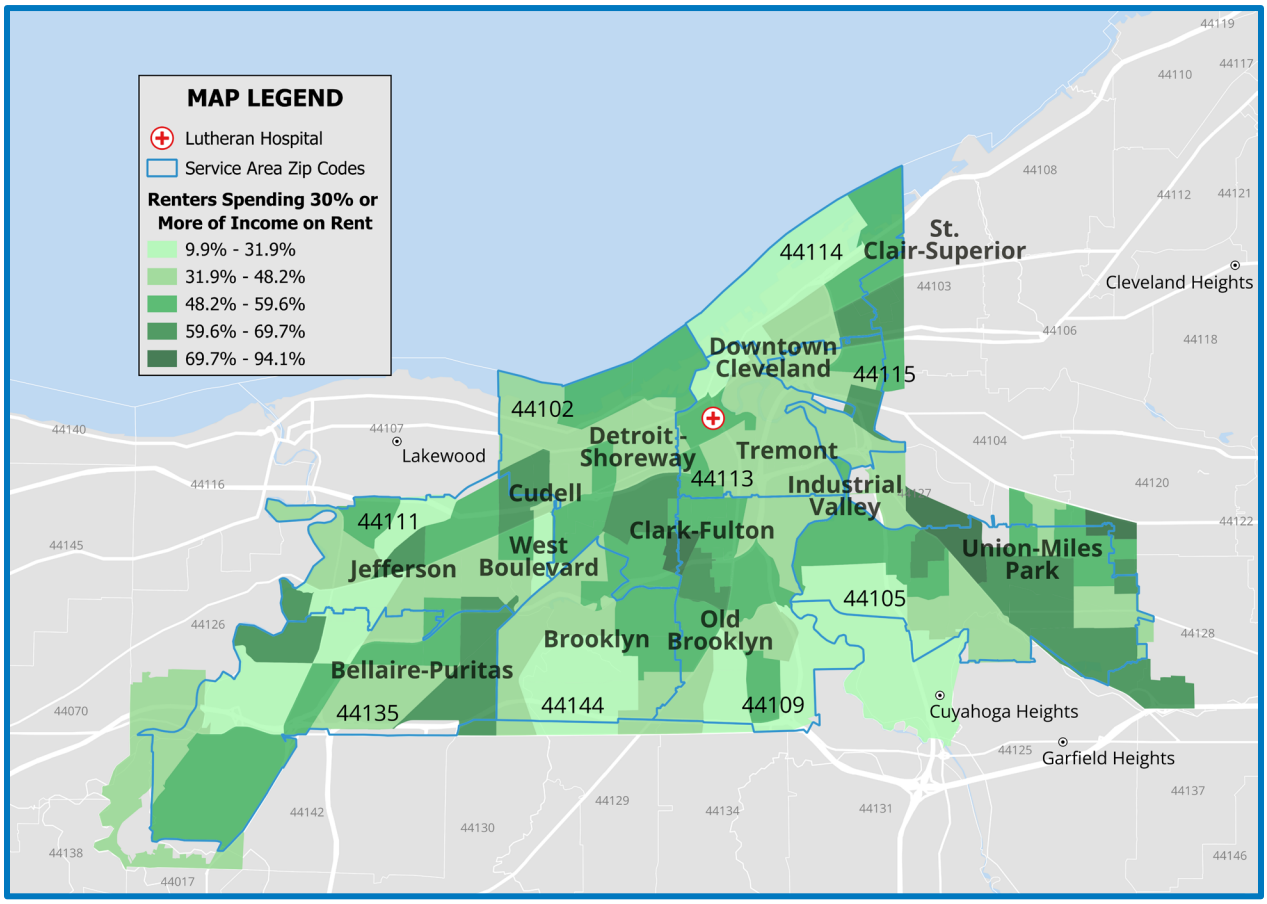
[5] Robert Wood Johnson Foundation, Education and Health. https://www.rwjf.org/en/library/research/2011/05/education-matters-for-health.html

[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

Housing and Built Environment

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

Figure 5: High Rent Burden by Census Tract, Lutheran 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 Lutheran Hospital community are in the zip code 44115 (Industrial Valley), where only 74.6% of households have an internet subscription.

Community Health Indices

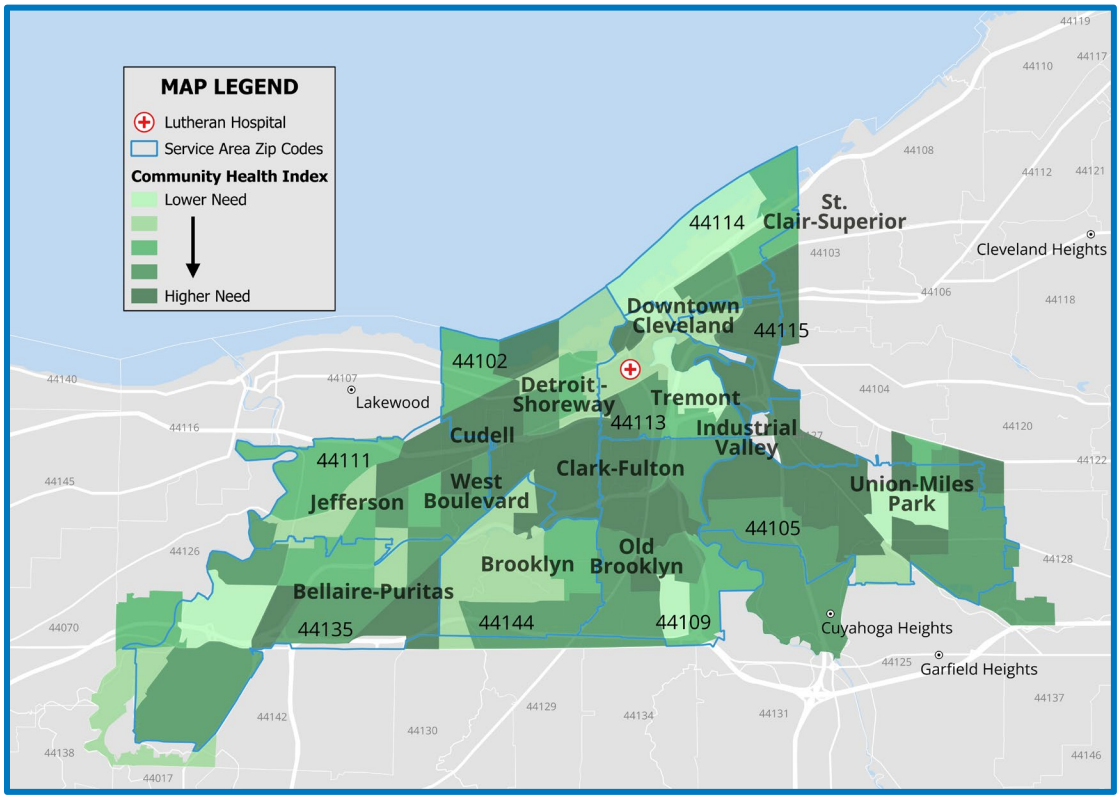
A map index that visualizes social and economic drivers of health at a specific geographic level serves as a critical decision-making tool by highlighting localized differences in health outcomes that may be obscured in broader geographic analyses. The three indices below highlight differences in community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

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

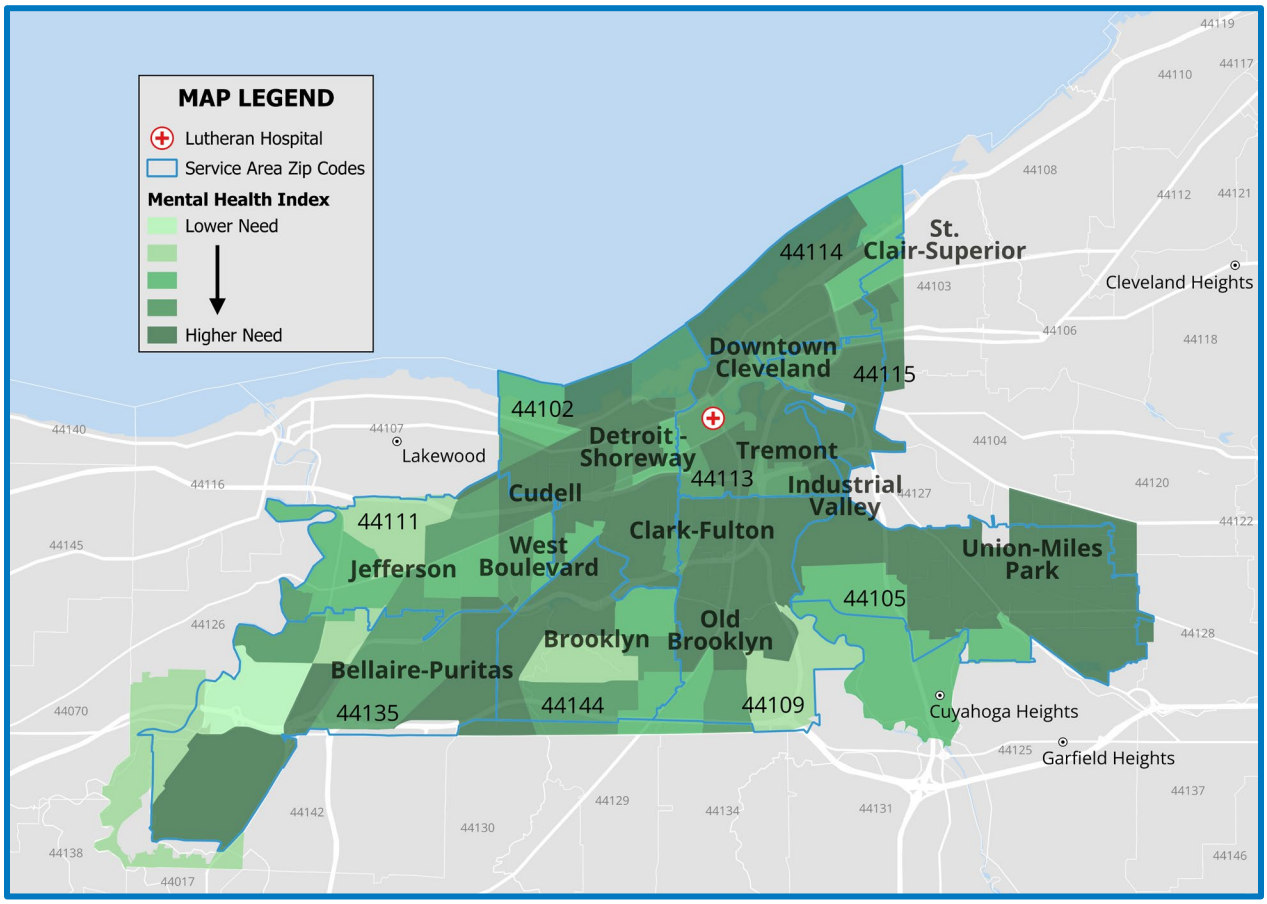


Mental Health Index

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 Lutheran Hospital Community, as indicated by the darkest shade of green. At the zip code level, 44105 (South Broadway) has the highest index value of the Lutheran Hospital Community. See Appendix B for additional details about the MHI and a table of MHI values for each zip code in the Lutheran Hospital community.

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

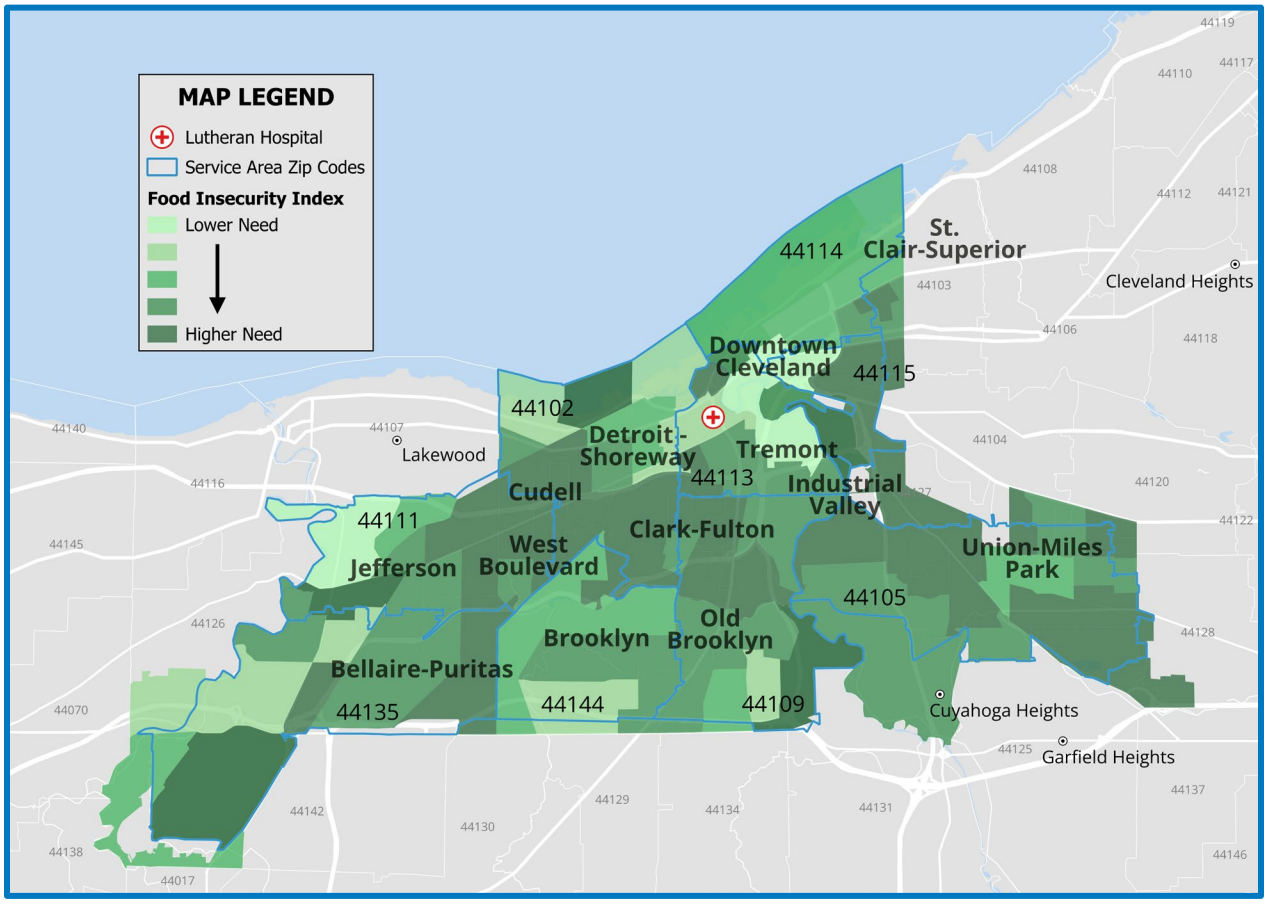


Food Insecurity Index

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 Lutheran Hospital Community, as indicated by the darkest shade of green. At the zip code level, 44115 (Industrial Valley) has the highest index value of the Lutheran Hospital Community. See Appendix B for additional details about the FII and a table of FII values for each zip code in the Lutheran Hospital community.

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



Other Community Assessment and Improvement Plans

An environmental scan of recent community health assessments, partner reports, and improvement plans relevant to the Lutheran Hospital community were researched and reviewed. Findings from this environmental scan reinforced the relevance of the five prioritized health needs identified in Lutheran 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 Lutheran 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 culturally and linguistically appropriate care.
- Behavioral Health:
    - Increased rates of depression, anxiety, and suicide among both youth and adults.
    - Significant unmet mental health needs and elevated levels of substance use, including youth drug use and adult overdose deaths.
- Chronic Disease Prevention and Management:
    - Statewide increases in diabetes and continued high rates of heart disease and hypertension.
    - Obesity and poor nutrition identified as key contributors to chronic conditions.
- Maternal and Child Health:
    - Stagnant or worsening maternal morbidity and infant mortality rates.
    - Persistent differences in birth outcomes, particularly for Black and low-income populations.
- Health-Related Social Needs:
    - Ongoing challenges related to poverty, housing affordability and quality, food insecurity, and transportation.
    - These social drivers of health are strongly linked to poor health outcomes across all priority areas.

[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 difference between individuals with mental health disorders and those accessing treatment or services
- High need for publicly funded behavioral health services
- Elevated rates of uninsured individuals limit access to necessary care

2023 Cuyahoga County Planning Commission Data Book[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
- Black and low-income residents are more likely to report poor mental health

Outdoor Spaces

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

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[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

Transportation

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

Housing

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

Social Participation

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

Respect & Engagement

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

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 and preschool enrollment 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

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

[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

Housing Stability

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

Primary Data Overview

Community Stakeholder Conversations

A total of 18 organizations provided feedback for the Lutheran 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 Lutheran 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
- First Year Cleveland
- Greater Cleveland Food Bank
- Lead Safe Cleveland Coalition
- LGBTQ+ Assessment Greater Cleveland / Cleveland Clinic
- Metrowest Community Development Organization
- NAMI Greater Cleveland
- Neighborhood Family Practice (FQHC)
- Union Miles Development Corporation

Across the community stakeholder conversations, participants consistently emphasized the importance of addressing behavioral health, particularly mental health and substance use disorder, noting a lack of accessible, affordable, and timely services, especially for youth, older adults, and low-income populations. Stakeholders expressed concern about rising youth suicide rates, fentanyl-related overdoses, and the stigma surrounding behavioral health, which continues to discourage care-seeking. Access to care was also a significant concern, with participants citing geographic barriers, long wait times, affordability challenges, and the need for culturally and linguistically appropriate care models. Chronic conditions such as diabetes, hypertension, and heart disease were

frequently mentioned as persistent health concerns, often connected to lifestyle factors, food insecurity, and the stress of living in unsafe or unstable environments.

Community members highlighted the influence of health-related social needs, including poverty, education, employment, transportation, housing, and digital access, as core influencers of health in the Lutheran Hospital community. These factors were consistently described as interrelated, with limited economic opportunity, housing instability, community violence, and inadequate access to healthy food shaping health outcomes across generations. Stakeholders also noted that neighborhood infrastructure, including sidewalk conditions, public safety, and environmental risks such as lead exposure, further complicates residents' ability to engage in preventive health behaviors or sustain chronic disease management.

Several respondents pointed to systemic issues such as underfunded services, workforce shortages, fragmented care delivery, and other on-going issues as the root causes of health outcome differences. Mistrust in institutions and the absence of continuity in care were seen as major deterrents to preventive health engagement. At the same time, stakeholders highlighted the role of trusted community-based organizations, schools, and faith-based groups as assets that could be leveraged to strengthen health promotion, social connection, and access to services. Together, these insights underscore the urgent need for coordinated, cross-sector strategies that integrate healthcare delivery with investments in social and economic supports 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 in infant mortality, particularly among Black infants in Cuyahoga County.
Health-Related Social Needs	"Poverty is the cause of these problems… living in poverty creates stress and that hurts your health."	This succinctly summarizes the foundational role poverty plays in shaping health outcomes. It reflects stakeholder recognition that economic instability is a root cause influencing other critical issues—such as chronic disease, mental health, housing insecurity, and violence. It also reinforces the importance of upstream, systemic solutions in improving community health.

Prioritization Methodology

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

Collaborating Organizations

The fifteen regional hospitals within the Cleveland Clinic health system in Northeast Ohio collaborate to share community health data and resources throughout the CHNA and implementation strategy processes. Lutheran 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 Lutheran 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 geography served by Lutheran Hospital, 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 Lutheran 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 Lutheran Hospital community:

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

Other Community Resources

A network of agencies, coalitions, and organizations provides a broad array of health and social services within the region served by Lutheran 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—including Cleveland—serves as a vital referral tool. United Way 2-1-1 contains information on organizations and resources in the following categories:

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

Additional information 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 Lutheran 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. Lutheran 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: Lutheran Hospital Community Definition

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

Figure 9: Lutheran 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 Lutheran Hospital Community Health Needs Assessment:

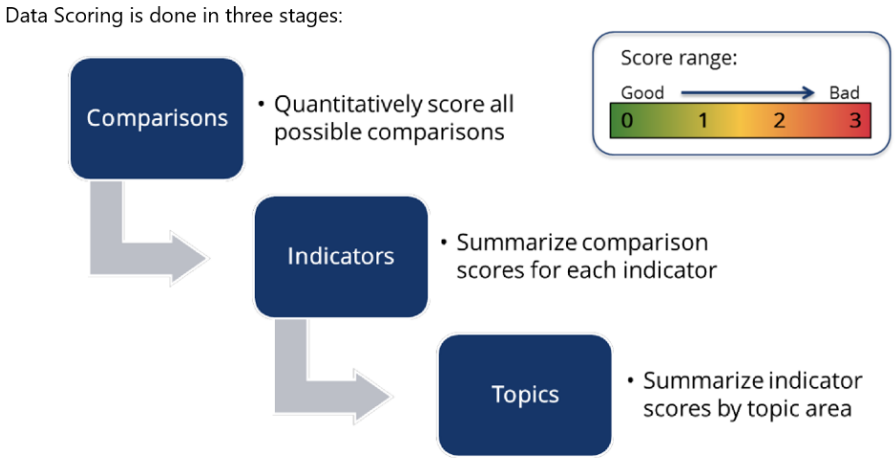
- American Community Survey
- American Lung Association
- Annie E. Casey Foundation
- CDC - PLACES
- Centers for Disease Control and Prevention
- Centers for Medicare & Medicaid Services
- Claritas Consumer Profiles
- Claritas Consumer Spending Dynamix
- County Health Rankings
- Early Ages Healthy Stages
- 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 Lutheran 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 Lutheran Hospital community.

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

Zip Code	CHI Value	FII Value	MHI Value
44102	95.9	96.4	98.5
44105	96.5	97.7	99.7
44109	94.5	93.8	97.9
44111	86.9	90.5	94.6
44113	82.0	84.1	91.7
44114	91.2	62.1	96.3
44115	99.9	99.9	99.6
44135	90.7	92.0	97.4
44144	77.3	83.6	93.2

Census Tract Key

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

Figure 12: Census Tract Key (Lutheran Hospital, North)

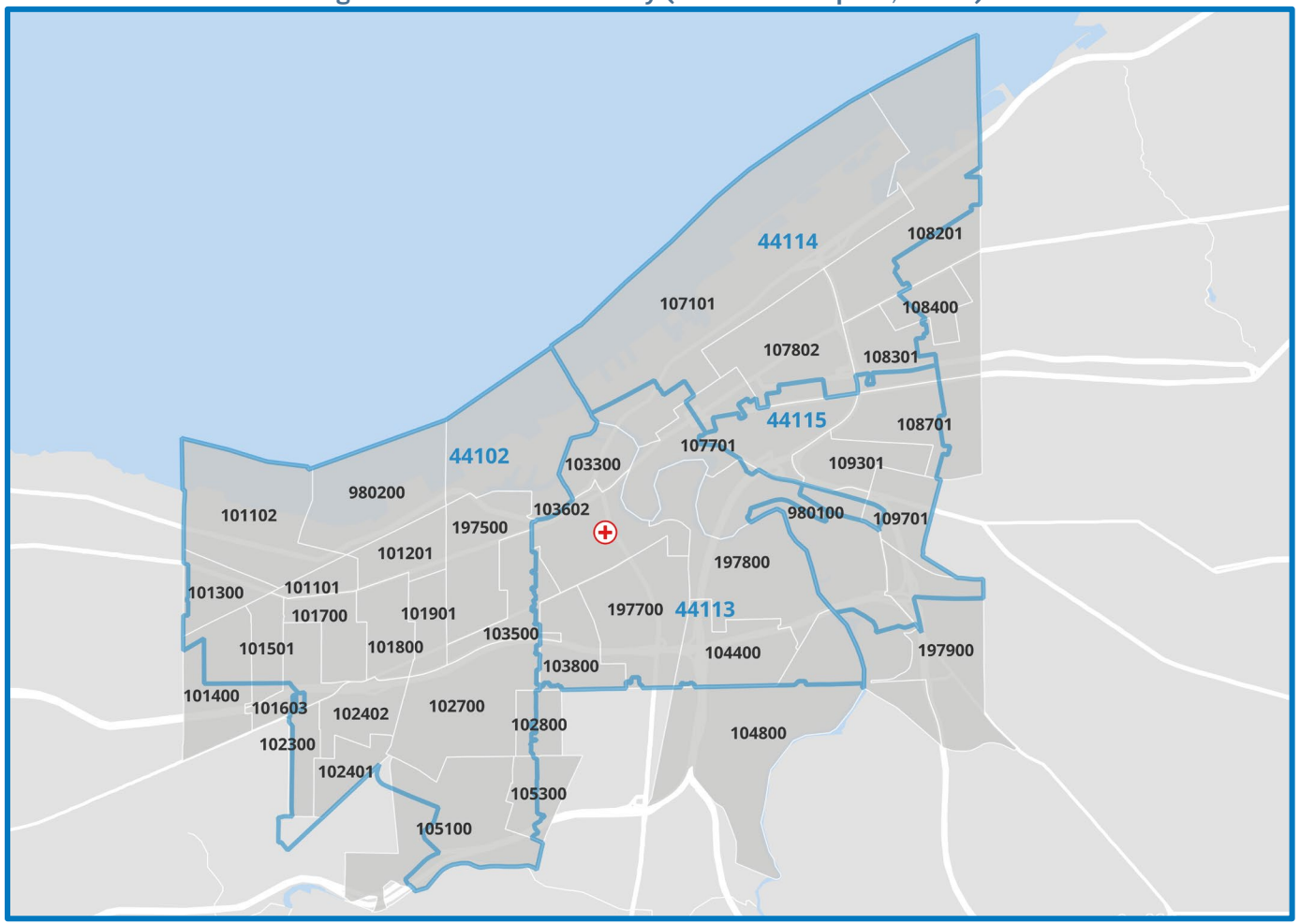


Table 5: Census Tracts by Zip Code (Lutheran Hospital, North)

44102	44113	44114	44115
101101	103300	107101	107701
101102	103602	107701	108301
101201	103800	107802	108701
101300	104400	108201	109301
101400	104800	108301	109701
101501	107701	108400	197900
101603	197700		980100
101700	197800		
101800	980100		
101901			
102300			
102401			
102402			
102700			
102800			
103500			
103602			
105100			
105300			
197500			
980200			

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

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

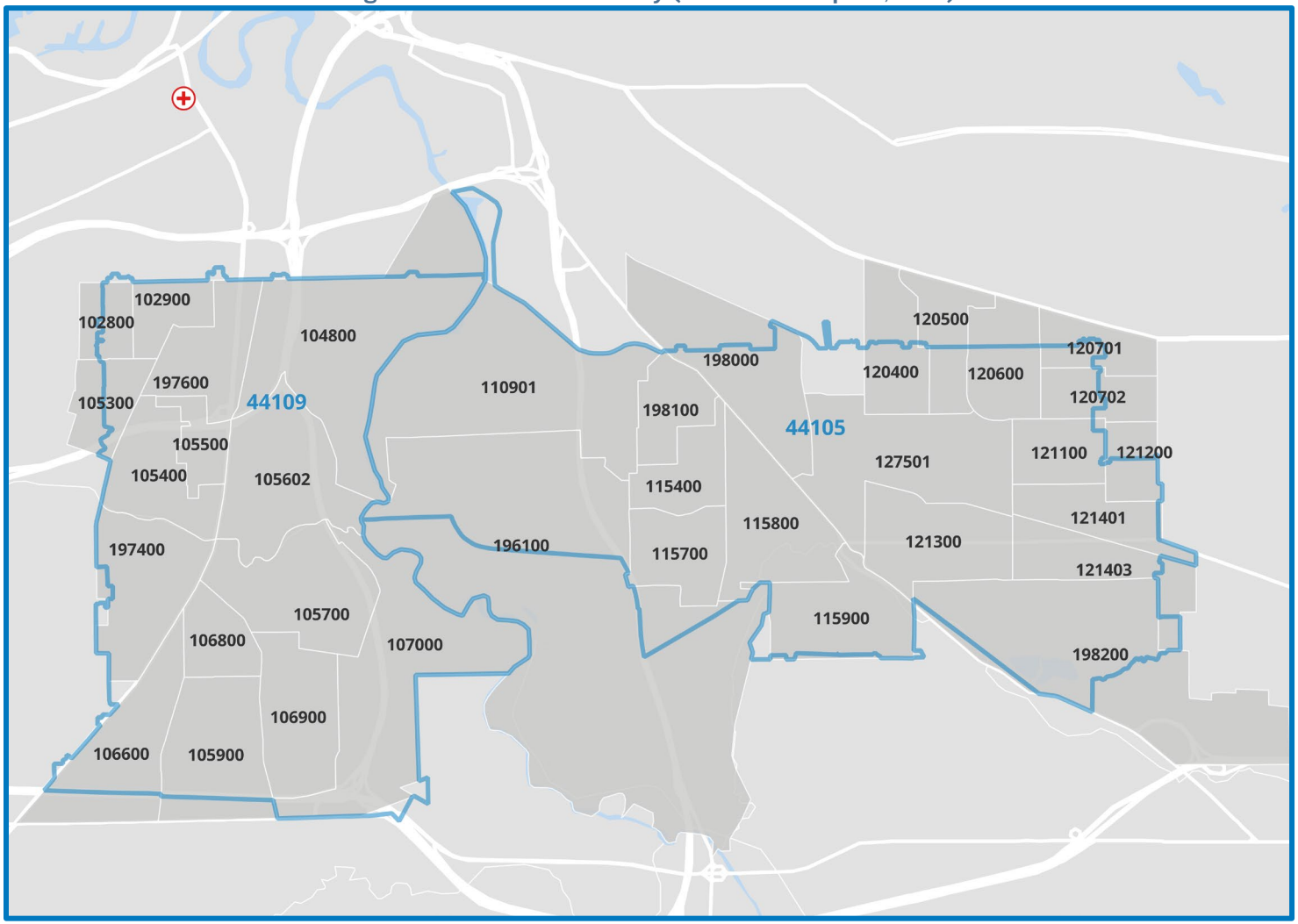


Table 6: Census Tracts by Zip Code (Lutheran Hospital, East)

44105	44109
110901	102800
115400	102900
115700	104800
115800	105300
115900	105400
120400	105500
120500	105602
120600	105700
120701	105900
120702	106600
121100	106800
121200	106900
121300	107000
121401	197400
121403	197600
127501	
196100	
198000	
198100	
198200	

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

Figure 14: Census Tract Key (Lutheran Hospital, West)

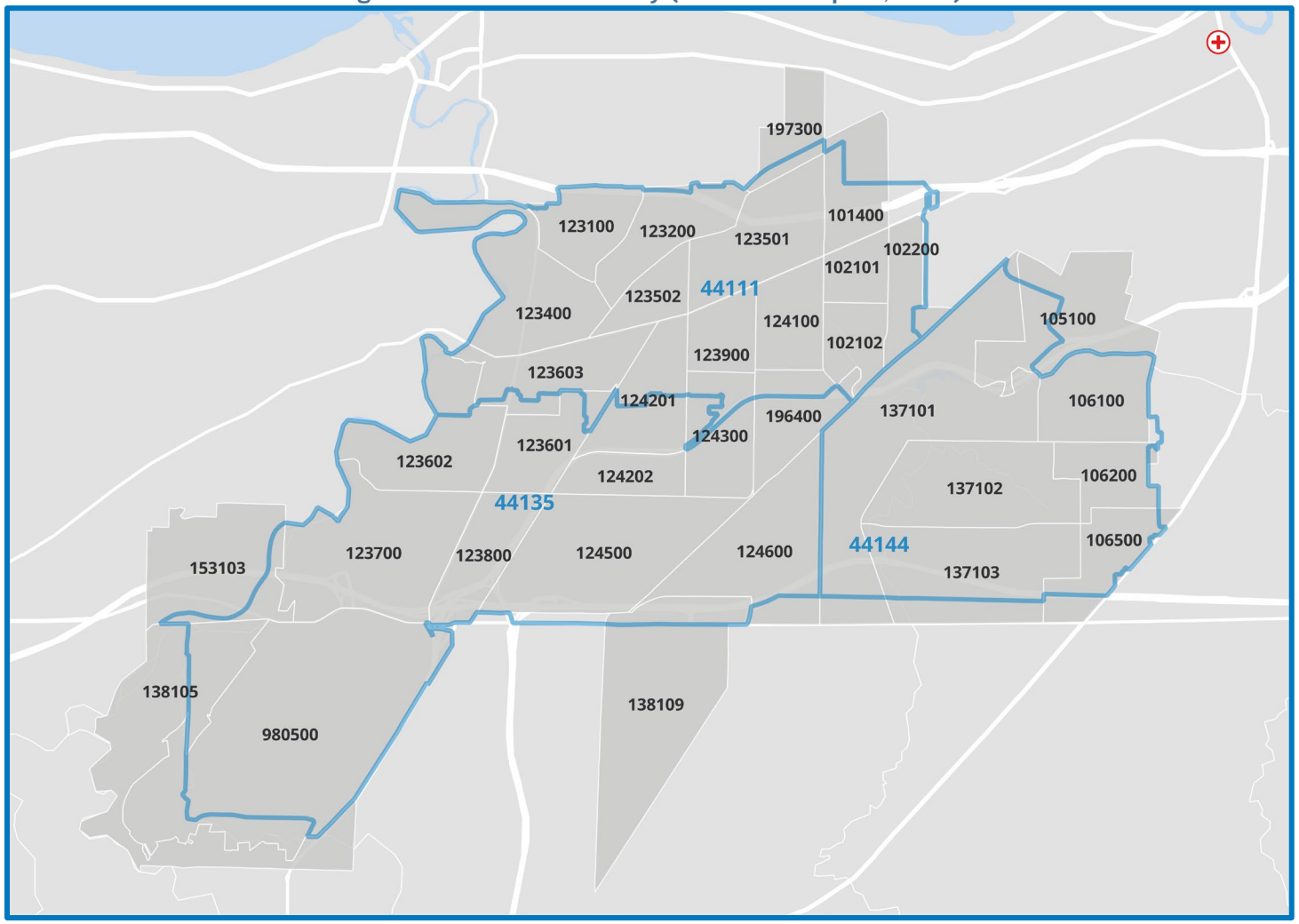


Table 7: Census Tracts by Zip Code (Lutheran Hospital, West)

44111	44135	44144
101400	123601	105100
102101	123602	106100
102102	123700	106200
102200	123800	106500
123100	124201	137101
123200	124202	137102
123400	124300	137103
123501	124500	
123502	124600	
123602	138105	
123603	138109	
123900	153103	
124100	196400	
124201	980500	
124300		
196400		
197300		

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 (CH) 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

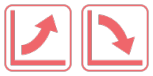
This report presents both Zip Code and Zip Code Tabulation Area (ZCTA) data. Zip codes, which were created by the U.S. Postal Service to improve mail delivery service, are not reported in this assessment as they may change, include P.O. boxes, or cover large unpopulated areas. This assessment covers 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 Table 3, 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 on Their Way To or From School	*percent*	9.1	*2023*	23
1.35	High School Students who Did Something to Purposefully Hurt Themselves Without Wanting to Die	*percent*	16.3	*2023*	23
1.35	High School Students who Drove After Drinking Alcohol	*percent*	3.2	*2023*	23
1.35	High School Students who Engage in Regular Physical Activity	*percent*	42.8	*2023*	23
1.35	High School Students who Ever Misused Prescription Pain Medication	*percent*	9.5	*2023*	23
1.35	High School Students who Feel Like They Matter to People in Their Community	*percent*	48.4	*2023*	23
1.35	High School Students who had a Check-up or Physical Exam	*percent*	73.4	*2023*	23
1.35	High School Students who had Been Stopped, Questioned, or Searched by Police	*percent*	15.3	*2021*	23
1.35	High School Students who had Mostly Negative or Negative Encounters With Police	*percent*	20.4	*2021*	23
1.35	High School Students Who Have Attempted Suicide: Past Year	*percent*	7.6	*2023*	23
1.35	High School Students who Obtained 8+ Hours of Sleep	*percent*	23.5	*2023*	23

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SCORE	EDUCATION	UNITS	CUYAHOGA COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.56	College Tuition Spending-to-Income Ratio	*percent*	14.7		12.9	12.4	*2024*	9
2.56	Day Care Center and Preschool Spending-to-Income Ratio	*percent*	8.7		7.5	7.4	*2024*	9
2.38	Student Loan Spending-to-Income Ratio	*percent*	5.5		4.8	4.7	*2024*	9
2.21	Home Child Care Spending-to-Income Ratio	*percent*	3.8		3.3	3.4	*2024*	9
2.21	Student-to-Teacher Ratio	*students/ teacher*	16.9		16.6	15.2	*2023-2024*	14
2.21	Vocational, Technical, and Other School Tuition Spending-to-Income Ratio	*percent*	1.8		1.6	1.6	*2024*	9
1.85	High School Graduation	*percent*	89.1	90.7	92.5		*2022-2023*	16
1.71	4th Grade Students Proficient in English/Language Arts	*percent*	60.2		64.1		*2023-2024*	16
1.71	8th Grade Students Proficient in English/Language Arts	*percent*	45.6		49.4		*2023-2024*	16
1.71	Veterans with a High School Diploma or Higher	*percent*	93.5		94.4	95.2	*2019-2023*	2
1.65	Children Served by Designated Ohio Healthy Programs (Count)	*children*	4,611				*2021*	11
1.65	Designated Ohio Healthy Programs (Count)	*programs*	73				*2021*	11
1.65	Families Served by Designated Ohio Healthy Programs (Count)	*families*	2,423				*2021*	11
1.65	Family Engagement Activities Supported by Designated 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 Lutheran 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
44102	41,880
44105	32,344
44109	37,444
44111	39,791
44113	21,091
44114	7,489
44115	10,323
44135	25,792
44144	20,879
Lutheran Hospital Community (Total)	237,033

Table 12: Age Profile of Hospital Community and Surrounding Geographies

Age Category	Lutheran Hospital Community	Cuyahoga County	Ohio
0-4	5.5%	5.2%	5.6%
5-9	5.8%	5.4%	5.7%
10-14	5.7%	5.6%	6.1%
15-17	3.5%	3.5%	3.8%
18-20	3.7%	3.9%	4.4%
21-24	5.2%	4.8%	5.3%
25-34	17.6%	13.5%	12.4%
35-44	14.2%	12.7%	12.2%
45-54	11.3%	11.2%	11.7%
55-64	12.5%	13.2%	13.0%
65-74	9.5%	12.1%	11.6%
75-84	4.1%	6.2%	6.1%
85+	1.3%	2.6%	2.2%
Median Age	37.5 years	41.4 years	40.5 years

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

	Lutheran Hospital Community	Cuyahoga County	Ohio	U.S.
White	49.0%	57.3%	75.7%	63.4%
Black/African American	26.6%	29.2%	12.8%	12.4%
American Indian/Alaskan Native	0.5%	0.2%	0.3%	0.9%
Asian	3.4%	3.6%	2.7%	5.8%
Native Hawaiian/Pacific Islander	0.1%	0.0%	0.1%	0.2%
Another Race	9.8%	3.1%	2.1%	6.6%
Two or More Races	10.7%	6.5%	6.4%	10.7%
Hispanic or Latino (any race)	20.5%	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

	Lutheran Hospital Community	Cuyahoga County	Ohio	U.S.
Only English	81.1%	88.5%	92.8%	78.0%
Spanish	12.8%	4.3%	2.3%	13.4%
Asian/Pacific Islander Language	1.4%	1.5%	1.0%	3.5%
Indo-European Language	3.0%	4.3%	2.8%	3.8%
Other Language	1.8%	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	Lutheran Hospital Community	Cuyahoga County	Ohio
Under $15,000	18.5%	12.8%	9.5%
$15,000 - $24,999	11.9%	9.1%	7.8%
$25,000 - $34,999	10.5%	8.7%	8.0%
$35,000 - $49,999	14.8%	12.5%	12.2%
$50,000 - $74,999	16.4%	16.5%	17.0%
$75,000 - $99,999	10.7%	11.9%	13.0%
$100,000 - $124,999	6.4%	8.4%	9.9%
$125,000 - $149,999	3.7%	5.8%	7.0%
$150,000 - $199,999	3.6%	6.2%	7.2%
$200,000 - $249,999	1.6%	3.0%	3.5%
$250,000 - $499,999	1.4%	3.4%	3.4%
$500,000+	0.5%	1.7%	1.6%
Median Household Income	$45,075	$60,568	$68,488

Table 16: Poverty Rates in Hospital Community and Surrounding Geographies

	Families Below Poverty
Lutheran Hospital Community	21.9%
Cuyahoga County	12.2%
Ohio	9.4%
U.S.	8.8%
Lutheran Hospital Zip Codes	-
44102	25.7%
44105	26.1%
44109	21.0%
44111	16.8%
44113	20.3%
44114	18.2%
44115	58.5%
44135	19.6%
44144	11.5%

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

Table 17: Educational Attainment of Hospital Community and Surrounding Geographies

	Lutheran Hospital Community	Cuyahoga County	Ohio	U.S.
Less than High School Graduate	16.7%	9.3%	8.6%	10.6%
High School Graduate	32.8%	27.2%	32.8%	26.2%
Some College, No Degree	20.7%	20.4%	19.6%	19.4%
Associate Degree	7.1%	8.3%	8.9%	8.8%
Bachelor's Degree	13.8%	20.4%	18.6%	21.3%
Master's, Doctorate, or Professional Degree	8.9%	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%
Lutheran Hospital Zip Codes	-
44102	50.1%
44105	51.8%
44109	50.6%
44111	46.3%
44113	38.7%
44114	48.4%
44115	44.6%
44135	53.0%
44144	40.7%

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%
Lutheran Hospital Zip Codes	-
44102	83.7%
44105	78.8%
44109	85.0%
44111	87.8%
44113	87.5%
44114	81.8%
44115	74.6%
44135	85.2%
44144	86.6%

All values: American Community Survey (2019-2023)

Appendix C: Environmental Scan and Key Findings

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

Cleveland Clinic

Building a healthy community together.

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

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

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

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

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

Section #1: Introduction

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

Section #2: Community Health Questions and Probes

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

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

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

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

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

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

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

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

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

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

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

Community Input Key Findings

A total of 18 organizations provided feedback for the Lutheran 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 Lutheran 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
- First Year Cleveland
- Greater Cleveland Food Bank
- Lead Safe Cleveland Coalition
- LGBTQ+ Assessment Greater Cleveland / Cleveland Clinic
- Metrowest Community Development Organization
- NAMI Greater Cleveland
- Neighborhood Family Practice (FQHC)
- Union Miles Development Corporation

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 key stakeholder interviews regarding access to healthcare in the community Lutheran Hospital serves. Participants identified persistent barriers that limit access to care, including transportation challenges, lack of culturally aware services, and affordability concerns, even among those with insurance coverage. There was also a strong emphasis on the need for integrated, co-located services that address multiple health-related needs in one setting. Importantly, trust and continuity with providers emerged as essential for meaningful engagement. These findings highlight the critical need for patient-centered, community-informed approaches to improve healthcare access.

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

- Geographic and transportation barriers: Participants noted that access is often limited by location, particularly in areas.

- Availability of care that is culturally responsive: There is concern that available services may not reflect the cultural or linguistic needs of populations.
- Insurance and affordability challenges: Affordability remains a major barrier, with participants citing gaps even among insured individuals.
- Need for integrated services: A strong desire for wraparound or co-located services (e.g., housing, mental health, food support) was expressed.
- Trust and continuity of care: Participants noted that trust in providers is essential for regular care utilization, especially in historically marginalized communities.

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

"Even with Medicaid, people are still struggling to afford prescription or follow-up visits."

"The first thing is services being accessible and close by. If someone has to take two busses to get care, they're not going to go."

"We need providers that look like the people they serve and understand their lived experience."

Community feedback consistently highlighted access to quality, affordable healthcare as a persistent challenge, particularly for populations across the community served by Lutheran Hospital. Participants pointed to barriers such as high costs, limited availability of providers, long wait times, transportation difficulties, and a lack of culturally responsive care. Even for those with insurance, many described struggles to afford prescriptions, specialty care, or consistent follow-up. Trust in the healthcare system and continuity of care also emerged as critical issues for some communities. These insights highlight the need for patient-centered strategies that integrate health and social services, prioritize cultural responsiveness, and remove logistical and financial barriers to care.

Behavioral Health: Mental Health and Substance Use Disorder

Mental Health

The feedback from community participants highlights significant behavioral health challenges in the community served by Lutheran Hospital, particularly in the areas of mental health and substance use disorder. Participants emphasized persistent barriers to accessing timely and appropriate mental healthcare, especially for youth, and noted the ongoing stigma surrounding mental illness. Substance use concerns focused on the rise of fentanyl-related overdoses and the need for more accessible, low-barrier treatment and harm reduction services. These findings underscore the urgent need for integrated, community-based strategies that address both prevention and care.

Participants also expressed concerns about high rates of mental health issues, substance use, and suicide attempts, especially among older adults and youth. There was a call for more education, awareness, and services that are culturally aware to address the stigma and barriers to accessing care.

The following are highlights of participant feedback regarding mental health:

- Access to Mental Health Services: Many participants described a shortage of mental health providers and long wait times, particularly for children and low-income individuals.
- Stigma and Community Perception: Stigma remains a significant barrier, preventing individuals from seeking mental healthcare.
- Integrated and School-Based Mental Health Supports: Several respondents noted the importance of embedding mental health services in schools and community hubs to increase access and normalize care.

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

"We've had families wait months just to get their child seen by a therapist – that's unacceptable."

"There's still this fear that if you say you're struggling, you'll be seen as weak or unstable."

"Having a therapist right in the school building makes a huge difference – kids feel safe, and it reduces barriers."

Substance Use Disorder

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

- Fentanyl and Opioid Crisis: Fentanyl was mentioned repeatedly as a driver of overdose deaths, especially in young adults and communities of color.
- Need for Harm Reduction and Treatment Services: Participants advocated for more harm reduction strategies like naloxone distribution, as well as expanded access to treatment and recovery services.
- Community-Based Prevention and Education: There was strong support for prevention programs, especially those targeting youth and families through trusted community organizations.

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

"It's everywhere – fentanyl is in everything now, and people don't even know what they're taking."

"We need more treatment centers that don't have a waitlist and don't require you to jump through hoops to get help."

"We have to get kids early – education, mentorship, and prevention matter just as much as treatment."

Findings related to behavioral health, encompassing both mental health and substance use disorder, revealed significant concerns across the Lutheran Hospital Participants cited widespread barriers to timely, affordable, and culturally appropriate mental health services, with long wait times and provider shortages especially affecting youth, low-income families,

and communities of color. Stigma, lack of trust, and limited integration of behavioral health into primary care further compound access challenges. Substance use disorder, particularly related to fentanyl and opioids, was identified as a growing crisis, with community members calling for expanded harm reduction strategies, education, and low-barrier treatment options. These insights highlight an urgent need for more responsive, community-centered behavioral health systems that address both prevention and recovery while tackling the root causes of mental and substance use disorders.

Chronic Disease Prevention & Management

Nutrition & Healthy Eating and Wellness & Lifestyle

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

- Limited Access to Healthy Food Options: Participants highlighted the lack of affordable, accessible places to buy nutritious foods like fruits and vegetables.
- Perceived Gaps in Food Support Services: Some respondents expressed concern that food assistance programs often prioritize institutional partners over individuals in need.
- Importance of Early Nutrition Education: Several participants emphasized the value of teaching children the importance of healthy eating habits at an early age.
- Recreational Programs Supporting Health: Recreational activities, especially those geared toward youth, were seen as important contributors to overall wellness and chronic disease prevention.
- Lifestyle-Linked Chronic Conditions: Respondents frequently cited diabetes, hypertension, and obesity as key community health concerns, often linked to lifestyle and environment.
- Broader Conditions that Shape Wellness: There was recognition that chronic disease prevention is interconnected with broader factors like housing, green space, and employment.

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

> *"Getting to kids younger to help them understand how important it is to lead healthy lifestyles is really important."*

> *"Access to food and exercise are contributing to things like diabetes and cancer."*

Cancer

The analysis of participant feedback reveals that cancer is discussed primarily in the context of prevention, early detection, and access to screenings, particularly for populations. While cancer itself was not a dominant theme across all responses, participants who did raise the topic pointed to critical gaps and opportunities in screening and outreach efforts.

The following are highlights of participant feedback regarding cancer:

- Importance of Early Detection and Routine Screening: Participants emphasized the need for routine cancer screenings like mammograms and cervical cancer tests, particularly for populations who may not seek regular care.
- Access and Outreach for Immigrant and Refugee Communities: There is concern that immigrants and refugees often lack access to preventive services, including cancer screenings.
- Community-Based Health Events as Screening Opportunities: Events such as local health fairs and cultural festivals are seen as important access points for individuals who may not otherwise seek cancer-related care.
- Education and Willingness to Participate: Education and trust are essential in getting people to participate in screenings and seek care.
- Cancer Linked to Broader Health Determinants: Cancer was also mentioned in the context of broader health issues like diet, exercise, and environmental exposures (e.g., lead).

The following is a select quote illustrating feedback about cancer by a key informant:

"I would just say that making it (cancer screenings) more widely available...health screenings and preventative medicine to immigrants and refugees."

Diabetes, Heart Disease, & Stroke

The following are highlights of participant feedback regarding diabetes, heart disease, stroke, and other chronic conditions:

Diabetes

- High Prevalence and Early Detection: Diabetes is frequently cited as a top community health issue, with many participants noting it as one of the most common chronic conditions encountered.
- Challenges with Ongoing Management: The need for accessible and consistent follow-up care is emphasized, particularly for individuals newly diagnosed through emergency or hospital visits.
- Barriers Tied to Differences Health-Related Social Needs: Diet, environment, and access to resources were highlighted as key drivers of diabetes diagnosis across racial and income groups.

Heart Disease & Stroke

- Widespread Impact and Education Gaps: Participants noted that heart disease, high cholesterol, and stroke are common but often not well understood in terms of warning signs and risk.
- Lifestyle and Environmental Contributors: The connection between limited access to nutritious food, safe spaces for exercise, and increased rates of heart disease was repeatedly raised.
- Differences in Outcomes: Heart disease outcomes are described as significantly affected by income, race, and historical disinvestment.

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

The following is a quote from a key informant about diabetes, heart disease, stroke, and other chronic conditions:

"High blood pressure and diabetes is being driven by inadequate support for healthy behaviors."

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:

- Routine Monitoring and Community-Based Screenings" Older adults often engage in community events where health screenings (e.g., for blood pressure) are offered, but consistent follow-up and connection to care may be limited.
- Aging in Place and Home Modifications: Effective chronic disease management is closely tied to seniors' ability to remain safely in their homes. Physical modifications (e.g., grab bars, shower aids) support mobility and reduce complications related to falls or lack of physical activity.
- Dementia and Mental Health as Chronic Conditions: Cognitive decline, including dementia, was discussed as a chronic health concern for the aging population. Its management is complicated by underdiagnosis, stigma, and a lack of integrated services.
- Reluctance to Seek Care: Some older adults exhibit resistance to discussing or seeking treatment for chronic conditions, especially those related to mental health or cognitive function.
- Role of Social Support and Isolation: Chronic disease management is impacted by social isolation, which can lead to lapses in treatment adherence or missed medical appointments.

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:

"You see that with older adults…just sort of resistance to going in to talk about it. This is not fully addressed in the aging population."

"Older adults and the informal support or family members that may be providing some of their care deal with a lot of social isolation."

Community feedback on chronic disease prevention and management revealed widespread concern about the growing burden of conditions such as diabetes, heart disease, hypertension, and dementia, especially among low-income populations, older adults, and communities of color. Participants emphasized that chronic disease is not only a clinical issue but one deeply tied to social and environmental factors, including poor nutrition, lack of access to exercise spaces, housing instability, and limited transportation. They also highlighted gaps in early detection, ongoing disease management, and culturally appropriate health education. Importantly, respondents called for greater investment in prevention and lifestyle-based interventions, as well as more accessible, community-embedded services to support long-term health management. These findings underscore the need for coordinated and fair approaches that combine medical care with social supports to reduce the incidence and impact of chronic disease.

Maternal and Child Health

The participant feedback reveals significant concern and insight around Maternal, Fetal & Infant Health and Children's Health, with recurring themes related to differences in health outcomes, access to services, care models, and community-based solutions. The analysis below categorizes the feedback into core Prioritized Health Needs, each supported by participant quotes that reflect lived experience and community concern.

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

Maternal, Fetal & Infant Health

- High Rates of Infant Mortality and Maternal Health Differences in Health Outcomes: Many respondents cited disproportionately high infant mortality rates, especially among Black infants, and linked these outcomes to maternal conditions like hypertension and diabetes.
- Limited Access to Prenatal and Birthing Services: Access challenges include a lack of birthing facilities on the east side of Cleveland and situations where women resort to calling ambulances to reach hospitals.
- Culturally Centered and Community-Based Maternal Support: Programs like Birthing Beautiful Communities and doulas were praised for addressing gaps in care that is culturally aware, centering mothers, and offering prenatal to postpartum support.
- Systemic Gaps and Lack of Pediatric Providers: Respondents expressed concern about systemic underinvestment and noted a shortage of pediatricians entering the field.

Children's Health

- Early Education and Healthy Lifestyle Promotion: Stakeholders stressed the importance of reaching children early with health education, nutrition, and wellness programming.
- Mental Health Needs and Behavioral Supports: A strong theme emerged around the need for expanded mental health services for children, particularly those referred for psychiatric issues or in therapeutic school settings.

- Impact of Environment and Social Stress: The role of housing quality, community safety, and daily stress in shaping children's health and development was repeatedly emphasized.
- Lead Exposure and Environmental Health: 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:

"Black babies are twice as likely to die in Cuyahoga County...we have a very significant rate of infant mortality."

"We have higher rates of pregnancy, hypertension, and diabetes which is a huge risk factor for maternal mortality."

"Sometimes people are calling ambulances to get to their birthing facilities."

In summary, community feedback revealed deep concern and strong engagement around maternal and child health, particularly among populations disproportionately affected by poor outcomes. Participants emphasized the urgent need to address high rates of infant mortality, maternal complications, and limited access to prenatal and pediatric care. They highlighted persistent barriers such as provider shortages, transportation challenges, and a lack of culturally appropriate services. At the same time, community members expressed hope and appreciation for grassroots efforts, including doula programs and culturally centered birthing initiatives, which are helping to fill critical care gaps. These insights underscore the importance of advancing holistic, community-informed approaches that support maternal and child health from pregnancy through early childhood.

Health-Related Social Needs

Prevention & Safety

Key informant participant feedback from the Lutheran Hospital community reveals strong and interwoven concerns about health-related social needs and their relationship to prevention and safety. These concerns reflect the realities of living in under-resourced communities, where income differences, unsafe environments, and limited access to basic needs compound health risks. The analysis below outlines the key points and includes direct quotes to emphasize the community's lived experience.

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

- Poverty as a Root Cause of Health and Safety Issues: Poverty was repeatedly identified as the foundation of many public health problems, from housing instability to community violence and food insecurity.

- Violence, Crime, and Lack of Safety: Gun violence, unsafe streets, and fear in neighborhoods were prominent themes. These conditions were said to increase stress, trauma, and reduce community trust and mobility.
- Affordable Housing and Infrastructure Gaps: Safe, stable, and affordable housing was cited as foundational to health, but many participants said there are few available options.
- Employment, Wages, and Economic Mobility: Unemployment, underemployment, and lack of livable wages prevent families from accessing care, food, and housing.
- Need for Upstream Investment in Prevention: Many participants expressed frustration that funding prioritizes reactive services rather than upstream prevention (e.g., lead poisoning prevention, education, housing investment).
- Education as a Tool for Safety and Empowerment: Education—both formal and health-related—was viewed as a pathway out of poverty and a preventive strategy for long-term well-being.

This feedback underscores the importance of addressing social drivers of health through integrated community development, systems-level policy change, and increased investment in preventive infrastructure—especially in historically marginalized communities.

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

"Poverty is the cause of these problems…living in poverty creates stress and that hurts your health."

"People fear their safety. We have such poverty; there's violence that's associated with that."

Quality of Life (Community, Economy, Education)
Key informant feedback provides a rich portrait of the ways community, economy, and education shape overall quality of life in the Lutheran Hospital community. Respondents emphasized both the structural barriers residents face and the community strengths that can be leveraged to improve well-being.

The following are highlights of participant feedback regarding Quality of Life, including Community, Economy, and Education:

Community Infrastructure and Engagement

- The physical and social infrastructure of neighborhoods—including access to parks, grocery stores, clinics, and safe spaces—was described as fundamental to residents' sense of health, safety, and .
- Community engagement and place-based identity emerged as strong predictors of neighborhood strength, especially when residents have a say in local planning and programming.
- Access to neighborhood resources like recreation centers, senior programs, and community development corporations (CDCs) was described as variable and critical to improving quality of life.

Economic Opportunity and Stability

- Unemployment, low wages, and economic displacement (e.g., gentrification) were highlighted as critical barriers to well-being.
- Community members tied economic mobility directly to health, housing, and food access, noting that job training and workforce development programs must be linked to wraparound services.
- Some cited strong local institutions and healthcare systems as untapped engines of economic growth and hiring potential.

Education as Foundation for Well-being

- Education quality, access, and cultural relevance were discussed as key elements of community strength and resilience, especially for youth and immigrants.
- Community schools and educational programming were seen as potential hubs for broader social services, mental health support, and life skills training.
- Several respondents pointed to the role of education in promoting civic engagement and fairness.

This analysis highlights a clear community call to align policy, planning, and investment with the lived experiences and strengths of residents—especially in historically under-resourced areas.

The following are a selection of quotes illustrating feedback about Quality of Life, including Community, Economy, and Education by key informants:

"Home is what matters. So having affordable, decent housing is important."

"We need to have a system where people are paid in a way that they can afford food and housing."

"We're not doing enough around prevention...that really lies in policy and systems change."

"It's also things like the walkability of the neighborhood, condition of the sidewalks, access to public transit – all those kinds of things are part of a healthy community."

"The hospitals are a huge engine of economic development...there is an opportunity to work with community organizations to create pipelines to jobs."

Overall, community feedback strongly underscored the critical role that social driver of health play in shaping overall well-being across the Lutheran Hospital community. Participants highlighted persistent and interrelated challenges in housing, education, employment, transportation, food access, and neighborhood safety, each of which contributes to differences in health outcomes and reduced quality of life. Residents expressed a desire for stronger community infrastructure, more accessible preventive services, and policies that invest in more equal economic opportunity and education. The findings reflect the urgency of addressing these upstream factors through coordinated, community-informed strategies that centers the lived experience and strengthens the foundations of health at both individual and neighborhood levels.

Appendix E: Impact Evaluation

Actions Taken Since Previous CHNA

Lutheran 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 numerous 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 Health Care

Actions and Highlighted Impacts:

A. Bilingual Patient Financial Advocates assisted patients in evaluating eligibility for financial assistance or public health insurance programs. 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 2023, Cleveland Clinic health system provided over $261 million in financial assistance to its communities in Ohio, Florida, and Nevada.

B. Lutheran Hospital provided bilingual signage, interpretation, and employ of bilingual caregivers specializing in internal medicine, gastroenterology, hepatology, general surgery, cardiology, and psychiatry to meet the needs of the local Spanish-speaking population. Lutheran Hospital's Hispanic Clinic provided space where patients met with bilingual care teams that understood Hispanic culture. The hospital offered bilingual Spanish-speaking specialists in cardiology, women's health, sleep medicine, exercise physiology, oncology, primary care, internal medicine, and palliative care.

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

D. The hospital expanded telehealth opportunities for behavioral health, endocrine, cancer and orthopedic care.

Behavioral Health

Actions and Highlighted Impacts:

A. The hospital's Alcohol and Drug Recovery Center (ADRC) continued to provide evaluation and treatment for people with alcohol and/or drug dependency problems throughout Cleveland Clinic communities. ADRC offered inpatient care, outpatient services, a supportive step-down care unit and a new Multidisciplinary Alcohol Program. Virtual visits were available for assessments as well as programs to ensure access.

B. 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.

C. Lutheran hosted *Addressing Substance Use Disorder in Healthcare,* an interprofessional event which included healthcare professionals, educators, and students from various institutions, along with community representatives from Metro, UH, Catholic Roundtable, and Nueva Luz.

D. 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.

E. The Psychiatric Treatment Resistance Program doubled patient evaluations in 2024 compared to 2023, raising awareness for early referrals for interventional treatments.

Chronic Disease Prevention and Management

Actions and Highlighted Impacts:

A. Continued the hospital's community outreach services addressing chronic health conditions, access and mental health and providing community education and resources. Community Health provided community programs addressing self-defense, macular degeneration, exercise benefits, sleep, arthritis, AED/CPR training and provided helmets and bike safety info to children. The hospital participated in *Convencion 2024*, with bilingual providers offering cancer screening FIT tests and health education.

B. Lutheran Hospital collaborated with community partners, including senior centers, schools, cultural centers, and CentroVilla25 to bring yoga and basic health screenings to serve the community.

C. In 2025, Lutheran opened a free Techno Gym, staffed with a bilingual exercise physiologist, to promote health and wellness.

D. The hospital's cancer team continued to provide a bilingual navigator on site. In 2024, Lutheran Hospital hosted a *Health With-In Reach* event and provided EKG, eye, and blood pressure screenings.

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 the Center for Infant and Maternal Health, Lutheran Hospital continued to support services for women at risk for pregnancy to improve success for mother long term and babies reaching their first birthday. Cleveland Clinic's Community Health Workers (CHWs) provided bilingual and Spanish speaking caregivers to aid the community. The CHWs provided education on safe sleep, diet, nutrition, screened for social drivers of health, and connected to resources to remove barriers to healthcare access. If eligible, mothers received food vouchers.

C. The hospital provided Saturday HPV/PAP clinics for early cervical cancer detection and prevention for uninsured community residents. The collaborative effort included the City of Cleveland Department of Health.

Health-Related Social Needs

Actions and Highlighted Impacts:

A. Lutheran Hospital continued a Cleveland Clinic community referral data platform (Unite Us) to coordinate health services and ensure optimal communication among social service providers. The system used a system-wide screening tool for adult patients to identify needs such as alcohol abuse, depression, financial strain, food insecurity, intimate partner violence, and stress. Collaborative efforts included University Hospitals and Metro Health.

B. Lutheran Hospital partnered with community-based organizations to improve access to healthy foods. Lutheran Hospital defined and secured a space for the future Nourish Pantry. Caregivers supported the annual community Thanksgiving Meal and cereal drives.

C. 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 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.

D. The hospital provided workforce development and training opportunities for youth K-12 in clinical and non-clinical areas, empowering Northeast Ohio's next generation of leaders. Lutheran offered workforce training, student presentations to schools and development opportunities in clinical areas such as nursing, pharmacy, physical therapy, and respiratory care. These efforts help mitigate provider shortages by ensuring a steady pipeline of skilled professionals.

E. 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.

F. Lutheran Hospital continued participation in the *CLE Homeless, Housing and Healthcare Collaboration,* a collaboration of Lutheran Community Advisory Council, National Alliance on Mental Illness (NAMI), Northeast Ohio Coalition for the Homeless, Legal Aid, and other community partners to provide education and assistance in addressing homelessness in the community. In 2024, the collaboration management transitioned to Cleveland's regional government. The work continued to provide housing for unsheltered individuals, including those with long-term homelessness and untreated disabilities. Lutheran Hospital continues to partner with and support the Sisters of Charity Health System, Joseph & Mary's Home for Medical Respite transition of care.

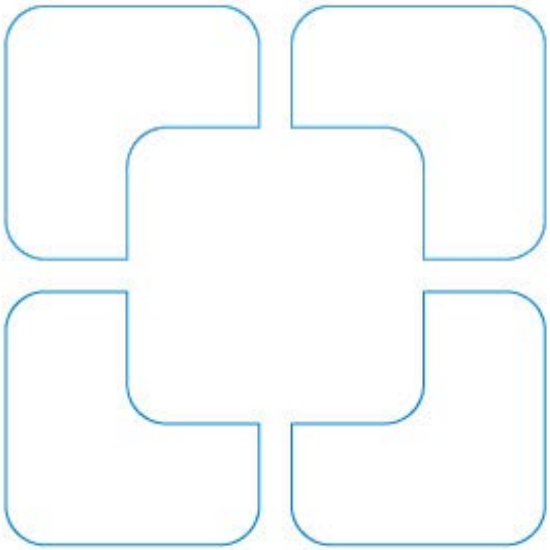
G. Cleveland Clinic provided transportation on a space-available basis to 1) patients within 5 miles of the Stephanie Tubbs Jones Health Center and Marymount, Euclid, Lutheran, and South Pointe Hospitals and 2) radiation oncology patients within 25 miles of Cleveland Clinic Main Campus, Hillcrest, and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

Appendix F: Acknowledgements

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

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Cleveland Clinic
Lutheran Hospital

Implementation Strategy Report

2025

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

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Lutheran 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 Lutheran 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 Lutheran 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

Lutheran Hospital, a member of the Cleveland Clinic health system, is a 192 staffed-bed[23] acute-care facility located in the Ohio City neighborhood near downtown Cleveland, Ohio. The hospital is recognized for its clinical excellence in several specialized areas, including spine and orthopedic surgery, behavioral health, and chronic wound care. Lutheran Hospital serves as a trusted healthcare provider for residents of Cleveland and surrounding communities, offering safe, high-quality care delivered by a skilled and compassionate team of healthcare professionals.

As part of the broader Cleveland Clinic health system, Lutheran 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

[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.

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 Lutheran, contributes to the system-wide advancement of clinical research and medical innovation. Patients at Lutheran Hospital benefit from access to novel treatments, clinical trials, and evidence-based practices developed and shared across the Cleveland Clinic network.

Lutheran 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 and reduction of barriers. It has received national recognition for excellence in patient safety and care quality, and remains committed to treating every patient with kindness, dignity, and respect.

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

Lutheran 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/lutheran-hospital.

II. Lutheran Hospital Community Definition

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



Table 1: Lutheran Hospital Community Definition

Zip Code	Neighborhood
44102	Detroit Shoreway
44105	South Broadway
44109	Brooklyn-Centre
44111	Jefferson
44113	Tremont
44114	Downtown Cleveland
44115	Industrial Valley
44135	Bellaire-Puritas
44144	Brooklyn

III. How Implementation Strategy was Developed

This Implementation Strategy was developed by members of leadership at Lutheran 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 Lutheran 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

Lutheran 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 the hospital's defined community continues to exceed state and national benchmarks in these areas, underscores the urgency of sustained, cross-sector efforts to address reducing differences in health outcomes across populations in the community served by Lutheran 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 Lutheran 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

The 2025 CHNA for the Lutheran Hospital community identifies Access to Healthcare as a persistent priority driven by longstanding structural and systemic barriers. Stakeholders emphasized affordability challenges, insurance gaps, transportation limitations, and a lack of culturally responsive care as major obstacles to timely, equal access. High

out-of-pocket costs, fragmented services, scheduling difficulties, and mistrust in the healthcare system further discourage consistent care, especially for lower-income residents. Participants stressed the need for integrated approaches that connect medical care with social supports such as housing, food access, and behavioral health. Secondary data highlight low insurance coverage, high insurance cost burdens, and elevated Community Health Index scores across all local zip codes, indicating widespread and concentrated access challenges.

Access to Healthcare Initiatives for 2026-2028 include:

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

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

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

B. **Initiative:** Collaborate with Federally Qualified Health Centers (FQHCs), community-based organizations, area hospitals, and local health departments to provide access and continuum of healthcare services.

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

C. **Initiative:** Provide bilingual signage, interpretation, and employ of bilingual caregivers to meet the needs of the local Spanish-speaking population.

   Anticipated Impacts: Improve health literacy, improve communication with providers, increase trust in providers.

B. Behavioral Health

The 2025 CHNA for Lutheran Hospital identifies Behavioral Health, encompassing mental health and substance use disorder, as a top community priority due to widespread service gaps and rising needs. Stakeholders reported increasing youth suicide risk, fentanyl-related overdoses, and persistent stigma that delays care. Severe provider shortages, long wait times, high costs, and fragmented systems make services difficult to access, particularly for low-income residents, youth, and older adults. Participants emphasized the need for culturally responsive, community-based approaches, expanded crisis and harm-reduction services, and better coordination across systems. Secondary data reinforce these concerns, showing high rates of poor mental health days, significant depression among Medicare populations, elevated Mental Health Index scores across all local zip codes, and drug poisoning and alcohol-related death rates well above national benchmarks.

Behavioral Health Initiatives for 2026-2028 include:

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

A. **Initiative:** As the Cleveland Clinic behavioral services designation, hospital will continue inpatient, outpatient and supportive step-down services provided through the Alcohol and Drug Recovery Center (ADRC), providing evaluation and treatment for people with alcohol and/or drug dependency.

   Anticipated Impacts: Improve access to treatment services and recovery support. Improve effectiveness of program with evidence-based practice and quantitative measures.

B. **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

The 2025 CHNA for Lutheran Hospital identifies Chronic Disease Prevention and Management as a top priority due to high rates of diabetes, heart disease, cancer, hypertension, kidney disease, and stroke, conditions strongly influenced by social, environmental, and lifestyle factors. Stakeholders emphasized barriers such as limited access to healthy foods, inadequate opportunities for physical activity, unstable housing, and financial constraints that delay early detection and consistent care. Concerns also centered on differences that affect all populations, including higher cancer mortality and disproportionate burdens of diabetes and kidney disease among certain populations. Older adults face additional challenges related to mobility, isolation, and costly support services. Together, these findings highlight the need for integrated, community-based strategies that combine clinical care with improved nutrition, wellness supports, and attention to broader social needs.

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 new community Smart Gym, provide classes focused on physical health, resources, and technology.

   Anticipated Impacts: Improve physical activity, improve nutrition, decrease stress, improve access to social services and assistance programs.

C. **Initiative:** Partner with Case Western Reserve University (CWRU), MetroWest Community Development Center, and Hispanic Center of Excellence to educate community members on healthy behaviors, access to care initiatives, and social services available with the community.

   Anticipated Impacts: Provide inclusive multi-language services and partnerships for community.

D. Maternal and Child Health 

The 2025 CHNA for Lutheran Hospital identifies Maternal and Child Health as a top priority due to persistent differences in health outcomes in infant mortality, birth outcomes, and childhood wellbeing. Stakeholders expressed concern about limited prenatal care access, maternal chronic conditions, geographic gaps in birthing facilities, and shortages of obstetric and pediatric providers. Families with low resources face compounded barriers including housing instability, stress, and institutional mistrust. Community-based, culturally grounded programs were highlighted as effective supports. Children's health concerns centered on behavioral health needs, early childhood development, nutrition, and exposure to violence and lead. Secondary data reinforce these challenges, showing elevated infant mortality, high rates of gestational hypertension and preterm births and significant social and environmental risks affecting children.

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

The 2025 CHNA for Lutheran Hospital identifies Health-Related Social Needs as a critical priority due to their pervasive influence on behavioral health, chronic disease, maternal and child health, and healthcare access. Stakeholders described how poverty, housing instability, unsafe neighborhoods, food insecurity, and limited digital and transportation access shape daily stress and restrict opportunities for health. Safety concerns, including high exposure to gun violence, along with inadequate housing and environmental risks like lead further undermine wellbeing. Participants emphasized the need for upstream investments such as early childhood education, job training, and neighborhood development, supported by trusted community institutions. Secondary data reinforce these challenges, showing high poverty rates, severe economic hardship, elevated violence, and concerning indicators across education and community conditions.

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 Greater Cleveland Food Bank and the West Side Market.

   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.

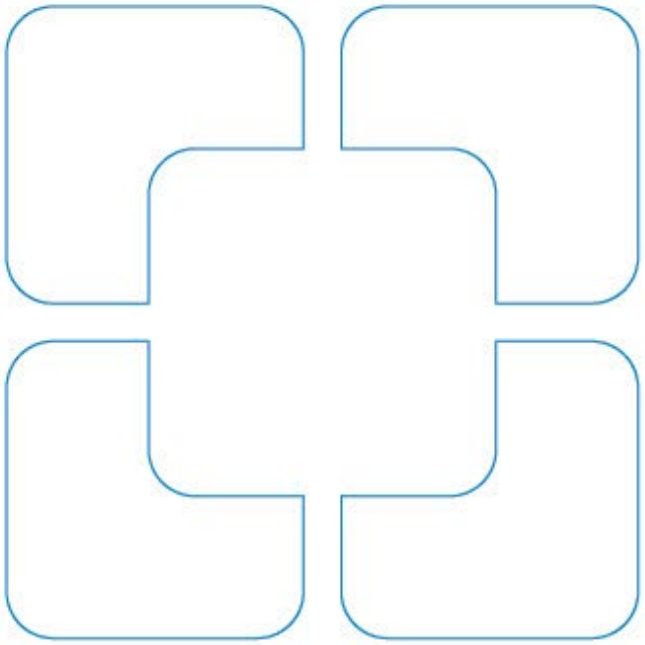
   Anticipated Impacts: Increase collaboration with community-based organizations, develop sustainable initiatives. Improve community awareness of available resources, develop a resource guide, and improve access to social supports.

D. **Initiative:** Provide workforce development and training opportunities for K-12 students in clinical and non-clinical areas, empowering Northeast Ohio's next generation of leaders.

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

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 Lutheran 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 Lutheran 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 .



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