Cleveland Clinic
Marymount Hospital

Community Health Needs Assessment

2025



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Marymount Hospital 2025 Community Health Needs Assessment

Introduction

Marymount Hospital, a 263 bed[1] acute care teaching hospital within the Cleveland Clinic health system, has served southern and southeastern Cuyahoga County since its founding in 1949 by the Sisters of St. Joseph of the Third Order of St. Francis. As the first community hospital to join Cleveland Clinic in 1995, the hospital provides a full continuum of services including emergency care, surgery, specialty programs, acute and sub-acute care, and outpatient rehabilitation. The hospital is also recognized for its leading orthopedic, endocrine, and behavioral health programs.

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

Marymount 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 health equity. 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, Marymount 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.

Marymount 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/marymount-hospital.

CHNA Background

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

Marymount Hospital Community Definition

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

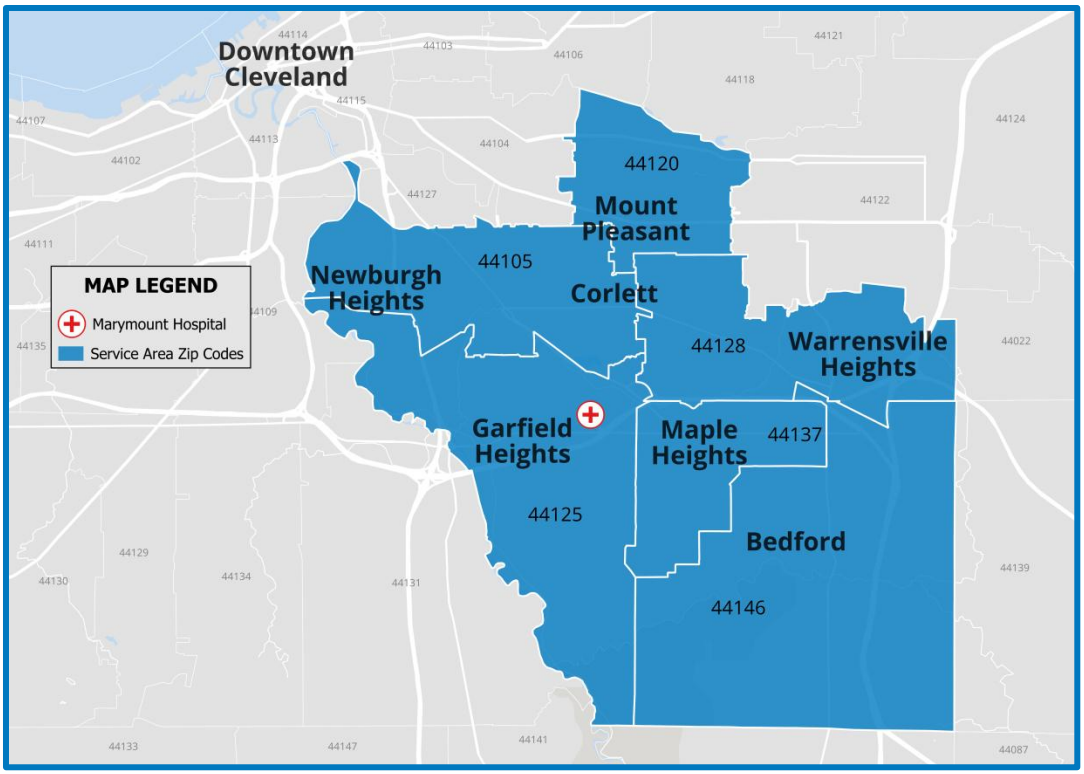


Table 1: Marymount Hospital Community Definition

Zip Code	Postal Name
44105	Newburgh Heights
44120	Mount Pleasant
44125	Garfield Heights
44128	Warrensville Heights
44137	Maple Heights
44146	Bedford

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 6-zip-code Marymount 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 geography and racial groups.

Other Community Assessment and Improvement Plans
An environmental scan was conducted to supplement quantitative data and further contextualize health needs across the hospital's defined community. This scan involved a review of recent community health assessments, needs reports, and partner studies across healthcare, public health, and social service sectors. Findings from local efforts, including reports from the nonprofits, hospital systems, and regional health collaboratives, corroborated the relevance of the five prioritized needs prioritized in this 2025 CHNA process for Marymount 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 racial and ethnic 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 Marymount community. Community stakeholders from a total of 18 organizations provided feedback. Participants represented sectors including public health, mental health, housing, food access, child and family services, and grassroots organizations. Feedback consistently reinforced the five identified health priorities and revealed community-specific challenges affecting health outcomes, such as long wait times for pediatric care, gaps in behavioral health support, housing-related health risks, and challenges accessing culturally competent prenatal care. Economic hardship was described as a root cause affecting every other health domain. Stakeholders called for expanded prevention, investment in community infrastructure, and system-level changes that address the underlying conditions shaping health across generations.

Summary

2025 Prioritized Health Needs

Marymount 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 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 and improve health outcomes across populations in the community served by Marymount Hospital.

The five prioritized community health needs identified in this 2025 Marymount Hospital CHNA are summarized below. Within each summary, pertinent information pertaining to secondary data findings, primary data findings and relevant demographics, social drivers

of health, and differences in health outcomes are highlighted. Full data details are included in the appendices section at the end of this report.

Prioritized Health Need #1: Access to Healthcare



Access to Healthcare remains a pressing challenge for the Marymount Hospital community for the 2025 CHNA, with stakeholders highlighting persistent barriers that disproportionately affect low-income residents, older adults, immigrant populations, and communities of color. Affordability was identified as a major obstacle, as high out-of-pocket expenses, inadequate prescription coverage, and the financial burden of follow-up care often discourage timely treatment. Transportation limitations, particularly for those living in outlying neighborhoods or with mobility challenges, further restrict access, while shortages of specialty providers and extended wait times contribute to delays in care. Behavioral health and pediatric services were consistently identified as areas of significant unmet need, underscoring gaps that extend beyond primary care.

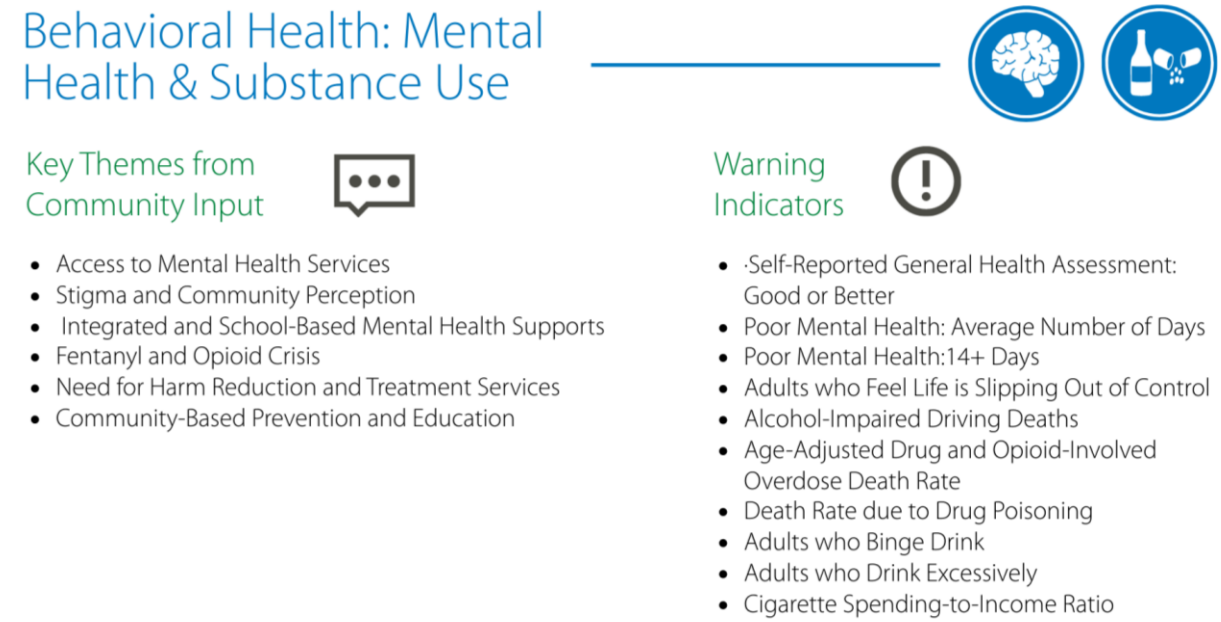
Stakeholders also emphasized systemic challenges that compound access issues, including fragmented service delivery, underfunded preventive care infrastructure, and persistent unmet needs across neighborhoods. Language and cultural barriers, coupled with experiences of discrimination, were cited as key drivers of mistrust in the healthcare system, reinforcing the need for expanded interpretation services and culturally responsive care. Older adults face additional hurdles such as navigating digital appointment systems, affording medications, and overcoming isolation, which limit their ability to engage in consistent care. Collectively, these findings point to the importance of coordinated, community-based solutions that integrate medical, behavioral, and social services, strengthen linkages between health systems and community partners, and prioritize prevention and continuity of care for Marymount's diverse population.

Based on secondary data from Cuyahoga County, the rate of adults who go to the doctor regularly for checkups (63.3%), and the rate of insured adults (72.1%), are both in the lowest quartile of all Ohio counties. Additionally, data on the county's Medicare population indicate a high rate of preventable hospital stays, compared to Ohio (3,677 vs. 3,269 discharges per 100,000 Medicare recipients). This rate is about 50% higher for the county's Black/African American Medicare population (5,651 discharges per

100,000). This likely indicates an especially high burden of hospital use as a main source of care at Marymount Hospital.

Geospatial data from Conduent HCI's Community Health Index (CHI) further underscore the magnitude of access challenges. The CHI estimates health risk based on social and demographic data associated with preventable hospitalizations and poor health outcomes. In the Marymount Hospital community, the zip code with the highest CHI score (96.5) is 44105 (Newburgh Heights). 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 emerged as one of the most urgent and complex priorities for the Marymount Hospital community in the 2025 Community Health Needs Assessment, with stakeholders consistently pointing to significant gaps in prevention, treatment, and recovery services. Depression, anxiety, trauma, and chronic stress were described as widespread concerns, often compounded by poverty, housing instability, and food insecurity. Youth, older adults, and residents from racially and ethnically diverse communities were highlighted as particularly vulnerable, facing stigma, language barriers, and limited access to culturally responsive care. Stakeholders also noted that the COVID-19 pandemic intensified these challenges, exacerbating stress and isolation while further straining the limited behavioral health workforce. Extended wait times, provider shortages, and fragmented care coordination were identified as persistent barriers that hinder early intervention and ongoing support.

Substance Use Disorder, particularly related to opioids and fentanyl, was described as a worsening crisis in the region, with stakeholders calling for expanded evidence-based treatment, harm reduction strategies, and integrated recovery services. Interviewees

emphasized the importance of trauma-informed and community-based approaches, including school-based supports and accessible crisis response services. They also underscored the need for stronger connections between healthcare, social services, and community organizations to address root causes and streamline pathways to care. Participants also called for greater investment in prevention and early identification, alongside expanded interpretation services and culturally appropriate programming to build trust among immigrant and minority populations. Collectively, feedback underscored that sustainable improvements in behavioral health will require coordinated cross-sector partnerships, expanded resources, and equity-focused strategies that respond to both the clinical and social dimensions of mental health and substance use.

Secondary data underscore the mental health challenges described by stakeholders. The percentage of residents reporting that their general health is good or better has been in significant decline since 2021 and remains lower than most other U.S. counties. The average number of days that county residents report their mental health as poor has similarly been trending upward since 2019.

Health risks related to substance use are comparatively high in Cuyahoga County. The death rate due to drug poisoning is more than twice the Healthy People 2030 target (45.5 vs. 20.7 deaths per 100,000). Across the county, 42.5% of all driving deaths involve alcohol. Both of these rates are in the highest quartile of all U.S. counties.

Conduent HCI's Mental Health Index (MHI) assesses mental health risk based on demographic and social factors associated to offer a more targeted understanding of mental health challenges. In fact, all six Marymount Hospital zip codes scored above 90 on the MHI scale, indicating severe challenges throughout the community. A more detailed breakdown of MHI values by census tract can be found in the *Prioritized Health Needs in Context* section below.

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)
- High Blood Pressure Prevalence
- People 65+ Living Alone
- People 65+ Living Below Poverty Level
- Chronic Kidney Disease: Medicare Population
- Osteoporosis: Medicare Population
- Stroke: Medicare Population
- Asthma: Medicare Population
- Rheumatoid Arthritis or Osteoarthritis: Medicare Population

Chronic Disease Prevention and Management continues to be a significant concern for the Marymount Hospital community, with diabetes, hypertension, cardiovascular disease, cancer, and kidney disease identified as particularly pressing issues. Stakeholders stressed that these conditions are not only highly prevalent but also strongly influenced by challenges such as poverty, food insecurity, and limited access to safe spaces for physical activity. Interviewees highlighted that while prevention and management strategies such as early detection, education, and consistent follow-up are essential, many residents face barriers related to affordability, transportation, fragmented care coordination, and insufficient access to specialists.

Participants also noted that chronic disease management is hindered by lifestyle factors tied to housing insecurity, stress, and limited community-based prevention programs. Stakeholders emphasized the importance of culturally responsive care models and the integration of chronic disease services with nutrition, behavioral health, and social support systems. Many participants called for more community-driven interventions, such as wellness and fitness programs, partnerships with local organizations to expand healthy food access, and efforts to reduce stigma associated with managing chronic illness. The need for enhanced patient education and outreach, particularly for older adults and racially and ethnically diverse populations, was also underscored. By strengthening preventive care infrastructure and addressing social and environmental

barriers, stakeholders believe Marymount can play a pivotal role in reducing chronic disease for all populations, improving quality of life, and decreasing preventable hospitalizations across its service area.

Primary and secondary data findings across topics such as nutrition, cancer, cardiovascular health, and aging consistently revealed differences in health outcomes influenced by income, race, location, and barriers in care delivery.

Nutrition, Healthy Eating, and Wellness

Stakeholders emphasized that nutrition, healthy eating, and overall wellness remain critical components in preventing and managing chronic disease in the Marymount Hospital community. Residents, particularly those in low-income neighborhoods, continue to face barriers such as limited access to affordable, fresh, and culturally relevant food options. Many neighborhoods were described as food deserts, where convenience stores and fast-food outlets dominate, making it difficult for families to maintain healthy diets. These food access challenges were linked to higher rates of obesity, diabetes, and hypertension in the community. Transportation limitations and financial strain further compound these issues, reducing residents' ability to travel to full-service grocery stores or farmers markets.

Stakeholders also pointed to broader wellness challenges, including insufficient access to safe and attractive spaces for physical activity, high stress levels associated with poverty and housing instability, as well as a lack of community-based wellness supports. Interviewees called for strategies such as expanding mobile and neighborhood-based farmers markets, increasing the number of community gardens, and embedding nutrition and wellness education into schools, churches, and workplaces. Culturally responsive nutrition programming, tailored to reflect local food traditions, was highlighted as particularly important for engaging diverse populations. Participants also advocated for sustainable funding and policy changes to expand healthy food access and to create infrastructure that makes active living more practical and appealing. Together, these strategies were viewed as essential to improving long-term health outcomes and reducing the chronic disease burden in the Marymount Hospital community.

Secondary data on consumer behavior indicate that adults in Cuyahoga County are more likely to rely on fast food, and less likely to cook meals at home, than nearly all other U.S. counties. Conduent HCI's Food Insecurity Index (FII) further illustrates food access concerns in the Marymount Hospital community, specifically. The two zip codes in this community with the highest FII scores, indicating the greatest food access challenges are 44105 (Newburgh Heights) and 44128 (Warrensville Heights) with scores of 97.7 and 97.2, respectively.

Cancer

Cancer remains a community concern in the Marymount service area, particularly around prevention, screening, and equitable access to timely care. Stakeholders emphasized the need to expand early detection through mobile screening units, health fairs, and community-based outreach, especially in schools, churches, and other non-traditional settings. However, barriers such as cost, lack of insurance, transportation challenges, and limited awareness of available resources continue to delay or prevent screenings. Concerns were also raised about differences in outcomes between population groups,

pointing to the importance of culturally tailored education, targeted outreach in high-risk neighborhoods, and integrated navigation services to connect residents with timely diagnostic and treatment options.

Secondary data illustrate that prostate cancer cases in Cuyahoga County are nearly 25% more common than the overall U.S. rate (139.3 vs. 113.2 per 100,000 males), and this rate is especially high for the county's Black/African American population (175.7 per 100,000 males). Black/African American males are also more than 65% more likely than the county's overall male population to die from prostate cancer (39.0 vs. 23.2 per 100,000).

In Cuyahoga County, rates of new breast cancer cases and rates of mortality due to breast cancer are both higher than most other U.S. counties, with the rate of new cases rising significantly. Compared to the overall county population, Black/African American females experience similar rates of new cases (126.6 vs. 136.1 per 100,000 females) but higher rates of mortality (28.5 vs. 21.9 per 100,000 females), suggesting potential differences in access to timely diagnosis, treatment, or follow-up care.

Diabetes, Heart Disease, Stroke, and Other Chronic Conditions

Stakeholders highlighted diabetes, hypertension, heart disease, and related chronic conditions as widespread and preventable yet often poorly managed across the Marymount Hospital community. These illnesses are frequently detected late, with many residents learning of their condition only through screenings at health fairs or temporary clinics rather than through ongoing engagement with a provider. Barriers such as limited access to affordable care, transportation challenges, health literacy gaps, and the financial burden of medications contribute to inadequate management and inconsistent follow-up. Participants stressed the importance of culturally relevant self-management programs, patient navigation support, and integrated education efforts that connect clinical care with nutrition, wellness, and behavioral health resources to improve outcomes and reduce preventable complications.

Secondary data illustrate the overall burden of diabetes and cardiovascular disease on the Cuyahoga County population, and indicate that these conditions are more common among the county's Black/African American population. For example, among the county's Medicare recipients, Black/African American individuals are about 50% more likely than the general population to have diabetes (35.0% vs. 23.0%). Chronic Kidney Disease, often a complication of unmanaged diabetes, similarly affects the county's Black/African Medicare population at a rate 50% higher than the county-wide rate (30.0% vs. 20.0%).

Stroke mortality in Cuyahoga County is 40.8 per 100,000—lower than the state average but well above the Healthy People 2030 goal (33.4) and rising. Among Medicare recipients, Black residents are more likely to experience heart failure (16% vs. 12% overall) and are also more likely to have hypertension (74% vs. 66%).

Older Adult Health

Older adults remain a priority population in the Marymount Hospital community, with stakeholders voicing concerns about the intersecting challenges of chronic disease management, social isolation, cognitive decline, and functional limitations. Many seniors

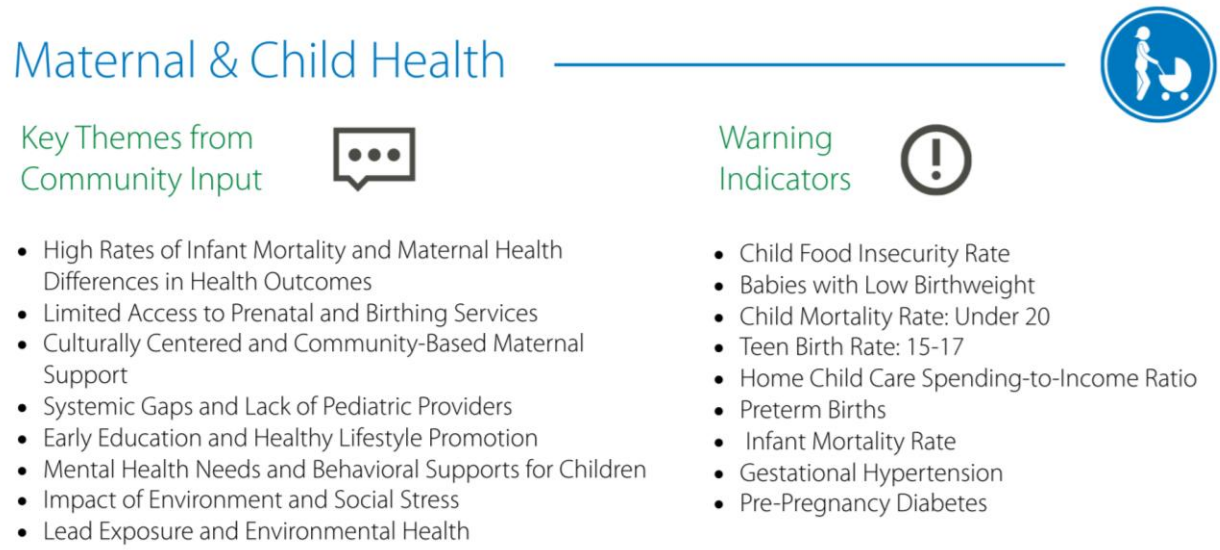
face barriers such as limited and unreliable transportation, high medical costs, and insufficient caregiver support, all of which restrict access to preventive services, routine appointments, and consistent treatment. These challenges contribute to delayed care and a greater risk of avoidable hospitalizations.

Participants emphasized the need for programs that support aging in place and expand access to primary, preventive, and mental health care for older adults. Strengthening community-based resources, such as home health programs, senior centers, and proactive outreach services, was seen as essential to improving quality of life, reducing preventable complications, and helping older residents maintain independence for as long as possible.

Based on scoring of secondary data indicators, Older Adult Health ranked as the fourth most concerning health need in Cuyahoga County. Over one-third of Cuyahoga adults aged 65+ live alone (36.1%), and 12.3% live below the federal poverty level—both figures exceeding national rates. These rates are likely especially high for the Marymount Hospital community, where rates of poverty are generally higher than the overall county. These factors, combined with transportation and care coordination barriers, place older adults at elevated risk for unmanaged chronic illness.

The high cost for adult day care may help to exacerbate older adult health issues. On average, adult day care costs 13.4% of a typical county resident's household income, and this cost is higher for Black households (18.6% of income) and Hispanic/Latino households (24.3% of income).

Prioritized Health Need #4: Maternal and Child Health



Maternal and Child Health remains a central concern for the Marymount Hospital community in the 2025 CHNA, with stakeholders highlighting ongoing differences in outcomes that are closely tied to social, economic, and systemic barriers. Interview participants emphasized that challenges such as limited access to comprehensive

prenatal and postpartum care, unstable housing, transportation difficulties, and inconsistent insurance coverage continue to place women, particularly those with low incomes and women of color, at greater risk for poor maternal and infant outcomes. The need for expanded access to wraparound supports, including doulas, culturally responsive care teams, and peer networks, were repeatedly stressed as ways to improve maternal experiences for all populations. Perinatal mental health also emerged as a significant need, with participants advocating for better integration of behavioral health screening and treatment into obstetric and primary care settings.

Children's Health was also viewed as an area requiring urgent attention. Stakeholders cited concerns about nutrition, preventive care, developmental screening, and the rising demand for pediatric mental and behavioral health services. Long wait times, provider shortages, and limited pediatric service availability were described as persistent barriers, leading to unmet needs in the community. Participants pointed to opportunities for strengthening collaboration among healthcare providers, schools, and community organizations to ensure that children have access to timely, comprehensive support in safe and nurturing environments. Holistic approaches that address both maternal and child health were seen as essential to fostering long-term improvements in health, educational attainment, and community well-being.

Based on secondary data from Cuyahoga County, one of the most significant challenges in this topic area is the overall mortality rate for children under the age of 20. Cuyahoga's child mortality rate (70.8 per 100,000) is in the highest quartile of all Ohio counties, and this rate is nearly double for the county's Black/African American children (129.1 per 100,000). Compared to the overall state of Ohio, Cuyahoga County has a high rate of youth not in school or working (2.7% vs. 1.7%) and violent crime (705.9 vs. 331.0 per 100,000)—two factors which may help to exacerbate the risk of mortality among young people. Additionally, relatively high rates of lead exposure add to pediatric health concerns in Cuyahoga County, despite improvements in recent years.

Several maternal and fetal health risks are higher in Cuyahoga County than most other counties across the state, including teen births (7.3 births per 1,000 females), preterm births (12.0%), and low birthweight (10.8%). Preterm births are more common for the county's Black/African American population (14.8%). Compared to Ohio overall, the rates of gestational hypertension and pre-pregnancy diabetes are also more common in Cuyahoga County and rising, posing health risks for both the infant and birthing parent.

Prioritized Health Need #5: Health-Related Social Needs



In the Marymount Hospital 2025 CHNA, Health-Related Social Needs emerged as a foundational driver of health, shaping outcomes across behavioral health, chronic disease, maternal and child health, and access to care. Stakeholders described how factors such as income instability, housing affordability, education access, and neighborhood safety directly impact residents' ability to access care, adopt healthy behaviors, and manage stress. They emphasized that these conditions create cumulative burdens for families, particularly for low-income households, older adults, and communities of color.

Participants highlighted entrenched economic differences, the lack of affordable and safe housing, and persistent transportation barriers as pressing concerns. Limited public transit and unsafe neighborhoods restrict access not only to healthcare, but also to jobs, schools, and community resources. Environmental conditions, such as food deserts and inadequate recreational spaces, were linked to higher rates of chronic illness and reduced quality of life. Education was described as both a protective factor and a pathway to better opportunities, yet differences in access to resources and quality perpetuate cycles of disadvantage. Stakeholders stressed that meaningful improvement requires cross-sector collaboration, targeted investments in housing and transportation, and community-driven strategies that dismantle systemic barriers while building resilient neighborhoods for all Marymount residents.

Economic opportunity in particular is a significant concern across Cuyahoga County. In fact, based on secondary data scoring, the topic of Economy ranked as the second most concerning of all health and quality of life topics in the county. Consumer data

demonstrate a high financial burden for many basic needs in Cuyahoga County, including housing rent (19.3% of household income), health insurance (7.1%), and adult day care (13.4%), outpacing both state and national averages. These burdens are likely especially high for residents of the Marymount Hospital community, where the median income is well below the county-wide median income ($46,471 vs. $63,671).

The topic of Education also ranks high among topics of concern, although many of the most concerning indicators here are also related to financial burdens. Cuyahoga County has a higher cost of college tuition (14.7% of household income), day care and preschool (8.7%), and home child care (3.8%), compared to state-wide and nation-wide rates.

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, inclusive, needs-based approaches to improve health outcomes. The following sections provide an overview of the demographic and social factors influencing health in the Marymount 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 Marymount 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 county) depending on data availability. When available, comparisons to county, state, and/or national values are provided. It should be noted that county level data may mask issues at the zip code level in many communities. While indicators may be strong when

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

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.

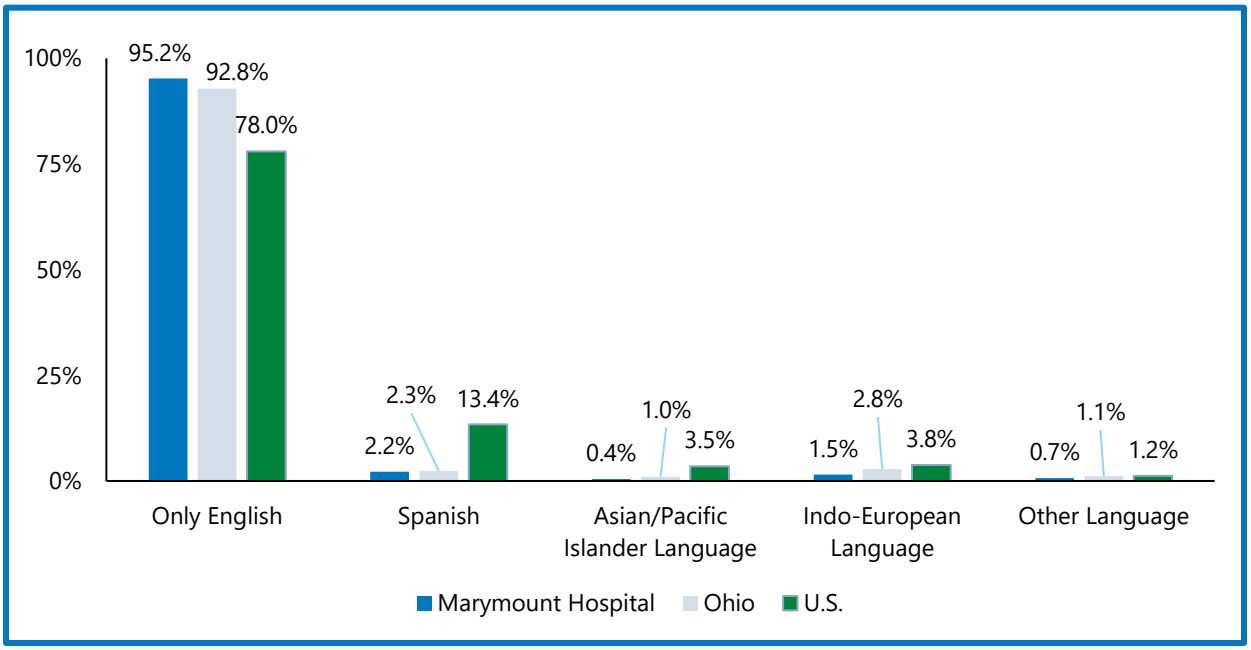
Population Demographics of the Marymount Hospital Community

According to the 2024 Claritas Pop-Facts® population estimates, the Marymount Hospital community has an estimated population of 173,526 persons. The median age in the community is 41.4 years, which is older than that of Ohio (40.3 years). About a quarter of the population (25.6%) is between 55-74 years old.

Black and African American residents make up the majority of the population, at 70.0%. White residents make up 22.2% of the population, and Hispanic and Latino residents make up 3.8% of the Marymount Hospital community.

As shown in Figure 2, the majority of the Marymount Hospital community aged five and above speaks primarily English at home (95.2%), followed by Spanish (2.2%). Spanish-speakers are less common in the Marymount Hospital community than the overall Cuyahoga County population (2.2% vs. 1.3%). Understanding countries of origin and language spoken at home can help inform the cultural and linguistic context for the health and public health system. Primary language spoken in the home can also be a proxy for acculturation into the community.

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



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

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

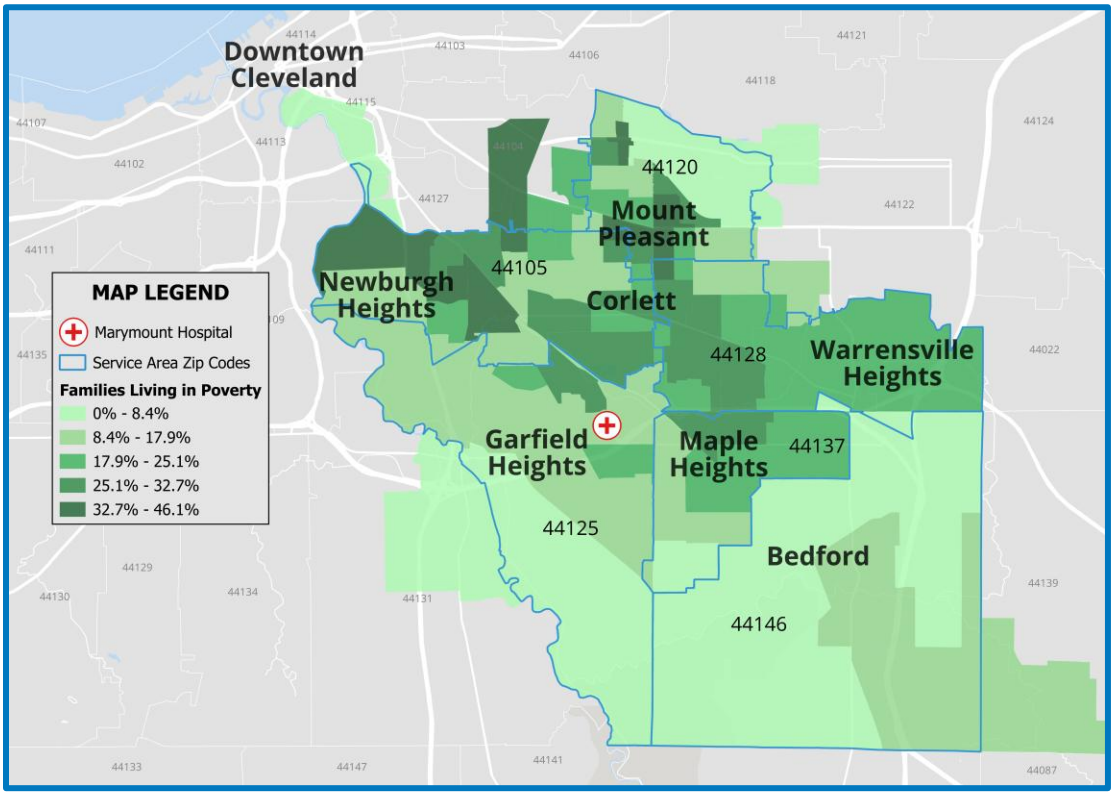
Income and Poverty

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 median household income for the Marymount Hospital Community is $46,471 which is lower than the surrounding county of Cuyahoga and the state of Ohio overall ($63,671 and $68,488, respectively).

Federal poverty thresholds are set every year by the Census Bureau and vary by size of family and ages of family members. In the Marymount Hospital Community, 18.0% of families live below the poverty level. This is nearly twice the state value (9.4%) and also higher than that of the surrounding Cuyahoga County (12.2%). Poverty levels also differ geographically across the Marymount Hospital community (Figure 3), and the highest concentrations are in zip code 44105 (Newburgh Heights), where more than quarter of the families live below the poverty level (26.1%).

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



Claritas Pop-Facts® (2024 population estimates)

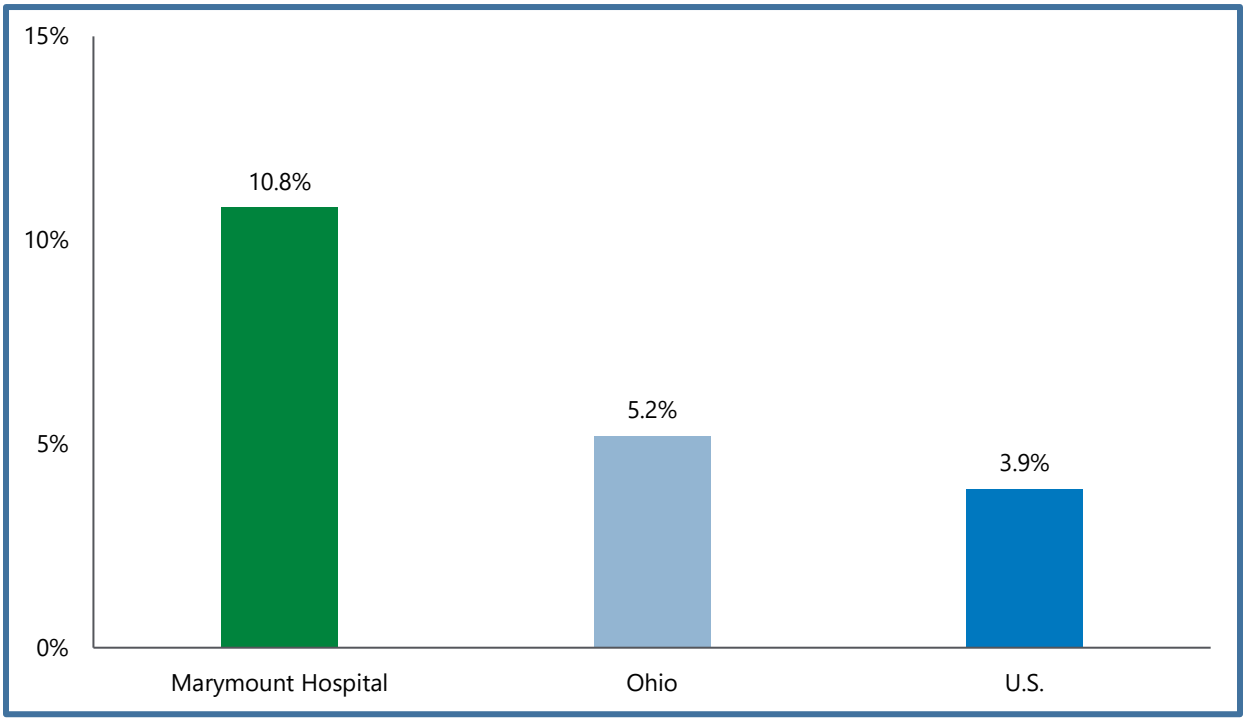
[4] Robert Wood Johnson Foundation. Health, Income, and Poverty. https://www.rwjf.org/en/library/research/2018/10/health--income-and-poverty-where-we-are-and-what-could-help.html

Education and Employment

The majority of the population within the Marymount Hospital community have a high school degree or higher (89.4%), although this is lower than the state-wide high school graduation rate (91.4%). Residents are also less likely than the overall Ohio population to have obtained a bachelor's degree or higher (20.5% vs. 30.9%).

The unemployment rate in the Marymount Hospital community is 10.8%—more than double Ohio's rate of 5.2%, and also much higher than the national unemployment rate (3.9%).

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



Service area and state values: Claritas Pop-Facts® (2024 population estimates)
U.S. value: American Community Survey five-year (2019-2023) estimates

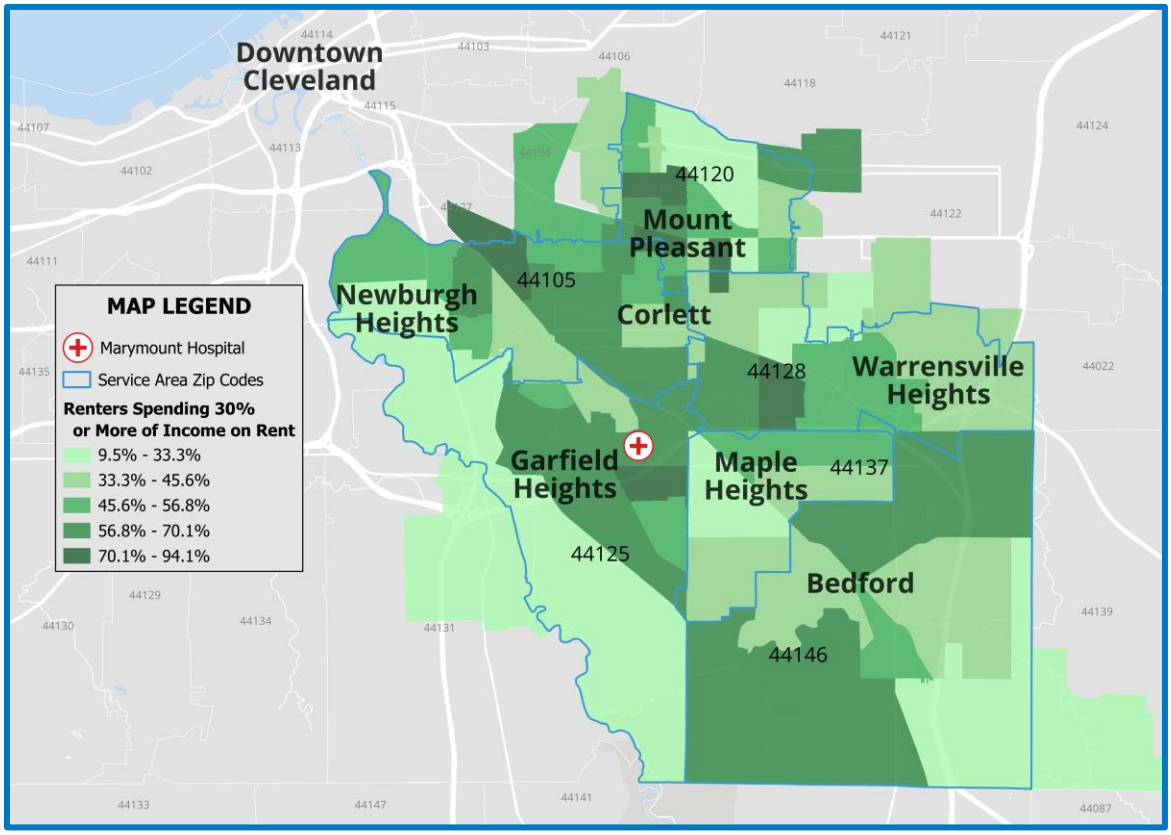
Education is an important indicator of health and wellbeing. Education can lead to improved health by increasing health knowledge, providing better job opportunities and higher income, and improving social and psychological factors linked to health.[5] Higher levels of education may also lead to better 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, Marymount 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 Marymount Hospital community are in the zip codes 44105 (Newburgh Heights) and 44120 (Mount Pleasant), where 78.8% of households and 78.9% have internet access, respectively.

Community Health Indices

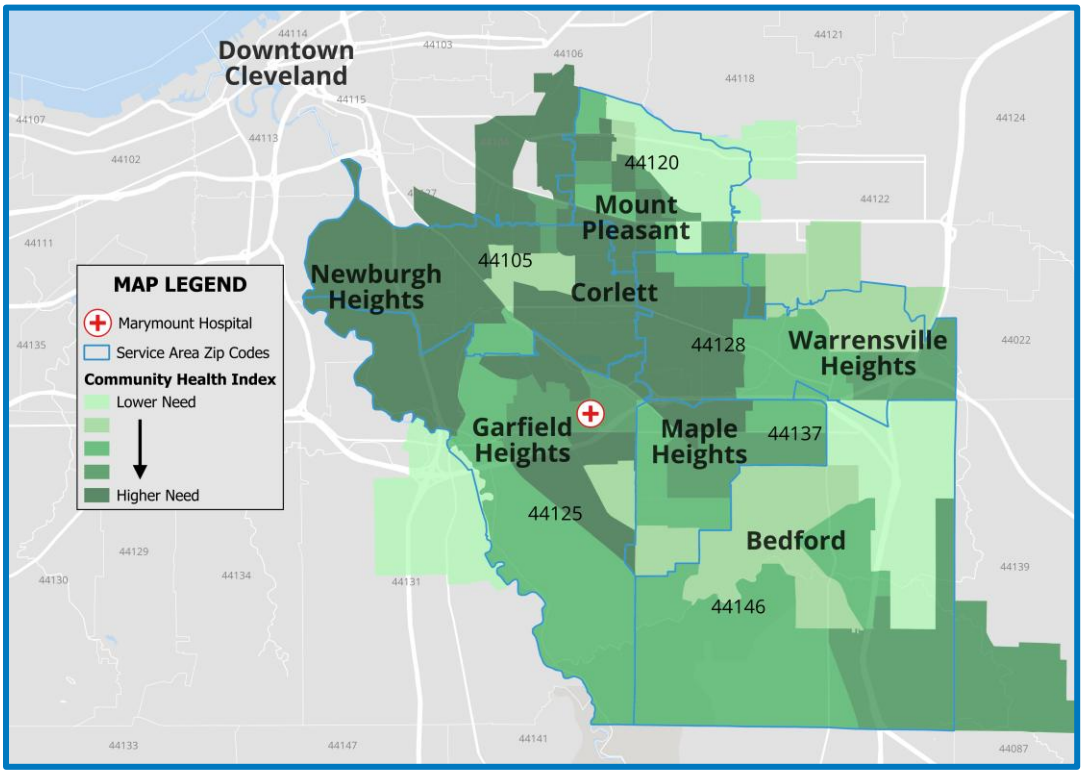
A map index that visualizes social and economic drivers of health at a specific geographic level serves as a critical decision-making tool by highlighting localized differences in health outcomes that may be obscured in broader geographic analyses. The three indices below highlight differences in community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

Community Health Index

Conduent HCI's Community Health Index (CHI) can help to identify geographic differences in health outcomes across the county, down to the census tract level. The CHI uses 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 Marymount Hospital community, as indicated by the darkest shade of green. At the zip code level, 44105 (Newburgh Heights) has the highest index value of the Marymount Hospital Community (96.5). See Appendix B for additional details about the CHI and a table of CHI values for each zip code in the Marymount Hospital community.

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

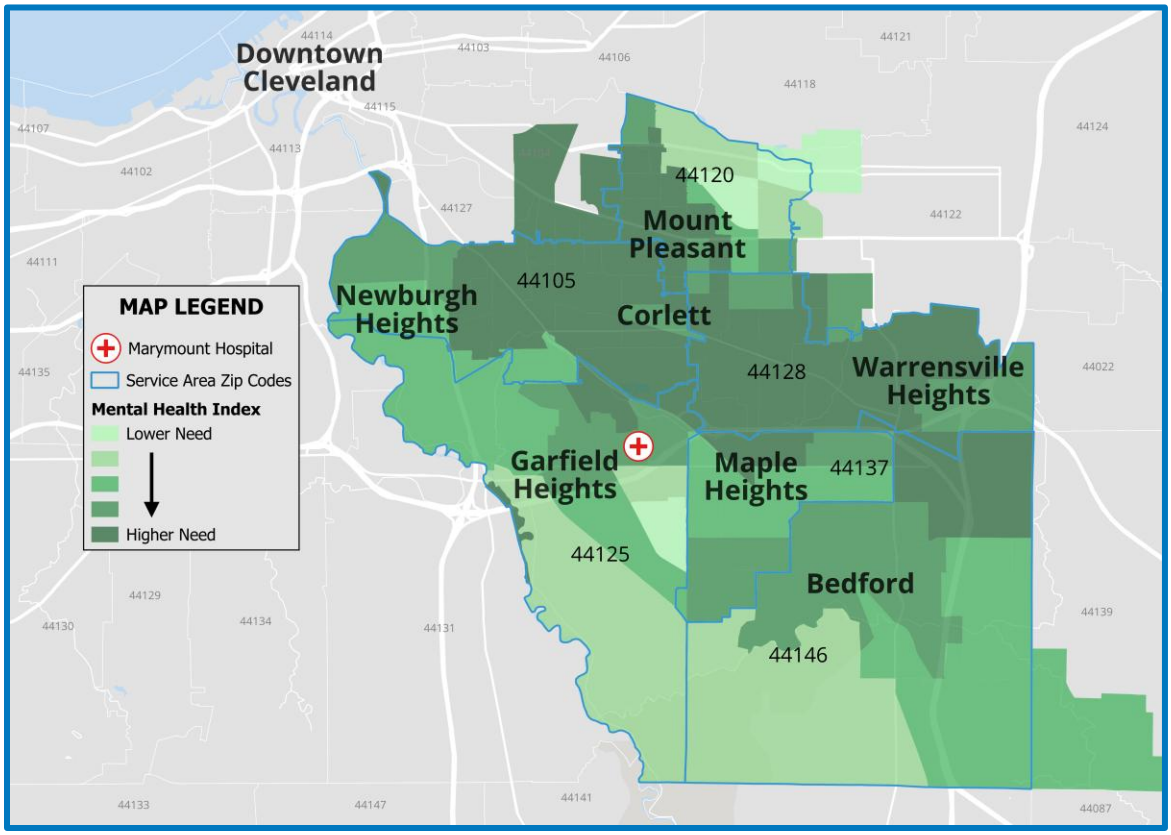


Mental Health Index

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 data on social needs and demographic characteristics that are 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 Marymount Hospital Community, as indicated by the darkest shade of green. Notably, all five zip codes in the Marymount Hospital Community have an MHI value above 90, suggesting especially high mental health needs throughout the region, compared to other U.S. zip codes. See Appendix B for additional details about the MHI and a table of MHI values for each zip code in the Marymount Hospital community.

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

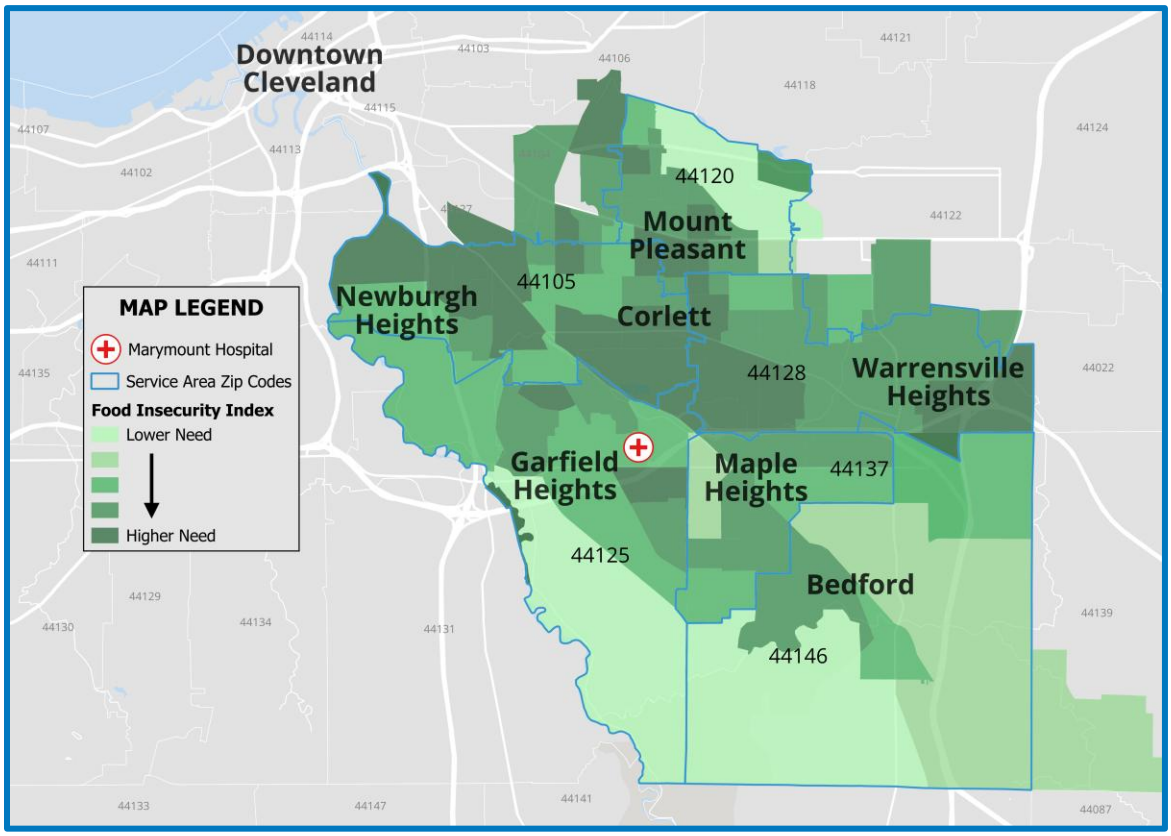


Food Insecurity Index

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 data on social needs and demographic characteristics 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 Marymount Hospital Community, as indicated by the darkest shade of green. Notably, four out of five zip codes in the Marymount Hospital Community have an FII value above 85, suggesting especially high food access needs throughout the region, compared to other U.S. zip codes. See Appendix B for additional details about the FII and a table of FII values for each zip code and census tract in the Marymount Hospital community.

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



Other Community Assessment and Improvement Plans

An environmental scan of recent community health assessments, partner reports, and improvement plans relevant to the Marymount Hospital community were researched and reviewed. Findings from this environmental scan reinforced the relevance of the five prioritized health needs identified in Marymount 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 Marymount Hospital's prioritized health needs:

- Access to Healthcare:
    - There are widespread healthcare provider shortages, especially in primary care and mental health.
    - Many Ohioans face barriers such as limited insurance coverage, low health literacy, and lack of cultural and linguistically appropriate care.
- Behavioral Health:
    - Increased rates of depression, anxiety, and suicide among both youth and adults.
    - Significant unmet mental health needs and high levels of substance use, including youth drug use and adult overdose deaths.
- Chronic Disease Prevention and Management:
    - Statewide increases in diabetes and continued high rates of heart disease and hypertension.
    - Obesity and poor nutrition are identified as key contributors to chronic conditions.
- Maternal and Child Health:
    - Stagnant or worsening maternal morbidity and infant mortality rates.
    - Persistent differences in birth outcomes, 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 differences between individuals with mental health disorders and those accessing treatment or services
- High need for publicly funded behavioral health services
- Elevated rates of uninsured individuals limit access to necessary care

2023 Cuyahoga County Planning Commission Data Book[10]

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

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[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 inclusiveness, empathy, and mutual respect 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 competency, and emergency preparedness
- Ensure active and visible support from government and local leadership for LGBTQ+ populations

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

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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

Outdoor Spaces

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

Transportation

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

Housing

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

Social Participation

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

Respect & Social Inclusion

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

Workforce & Civic Engagement

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

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

Economic Mobility

- Most children are unprepared for kindergarten, minority enrollment in preschool
- Childcare access hindered by staffing shortages
- Cleveland ranks as the 2nd poorest large U.S. city

[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

- Significant income differences by race

Health Pathways

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

Housing Stability

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

Primary Data Overview

Community Stakeholder Conversations

Community stakeholders from a total of 18 organizations provided feedback specifically for the Marymount 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 Marymount 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
- LGBTQ+ Assessment Greater Cleveland / Cleveland Clinic
- Lead Safe Cleveland Coalition
- Maple Heights City School District
- NAMI Greater Cleveland
- Union Miles Development Corporation
- University Settlement

Stakeholder discussions for the Marymount Hospital 2025 CHNA highlighted Behavioral Health as a top priority, with persistent gaps in availability, affordability, and access to care. Shortages of providers, long wait times, and limited crisis intervention options were

described as urgent barriers, particularly for youth, older adults, and culturally diverse populations. Stigma, language barriers, and lack of culturally responsive services further prevent residents from seeking timely support. Youth mental health, including depression, anxiety, and trauma, was identified as an area of growing urgency, often tied to family stress and the lingering effects of the COVID-19 pandemic.

Access to Healthcare and Chronic Conditions were also recurring themes. Residents face significant challenges related to transportation, geographic isolation, financial barriers, and service shortages, which limit preventive and ongoing care. Chronic diseases such as diabetes, hypertension, and obesity remain widespread and are often linked to poor nutrition, physical inactivity, and environmental stressors. Stakeholders emphasized the importance of expanding mobile services, integrated care models, and telehealth to better reach underserved residents.

Underlying these issues are challenges such as poverty, unemployment, unstable housing, and food insecurity, that profoundly shape health outcomes. Stakeholders identified barriers including gaps in funding for public services, reduced neighborhood investment, and persistent social and economic challenges as factors contributing to differences in health outcomes. They stressed the need for coordinated, cross-sector strategies that address both clinical care and upstream determinants of health, ensuring solutions are community-driven, culturally tailored, and sustainable over time.

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 buses 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."	This underscores significant differences in infant mortality.
Health-Related Social Needs	"Poverty is the cause of these problems… living in poverty creates stress and that hurts your health."	This succinctly summarizes the foundational role poverty plays in shaping health outcomes. It reflects stakeholder recognition that economic instability is a root cause influencing other critical issues, such as chronic disease, mental health, housing insecurity, and violence. It also reinforces the importance of upstream, systemic solutions in improving community health.

Prioritization Methodology

Marymount 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 population differences in areas such as access to care, behavioral health, chronic disease, and the social determinants 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, Marymount Hospital has prioritized the same five health needs for its 2026–2028 Implementation Strategy Report, ensuring continuity in addressing longstanding health challenges and advancing equitable 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. Marymount Hospital is part of the Cleveland Clinic East Submarket which includes Marymount, Hillcrest, South Pointe, Mentor, and Euclid hospitals.

Community Partners and Resources

This section identifies other facilities and resources available in the community served by Marymount 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 medically underserved areas. 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 Marymount Hospital community, community health services are further supported by local public health agencies, including the Cuyahoga County Board of Health. The following FQHC clinics and networks operate in the Marymount Hospital community:

- MetroHealth Community Health Centers
- 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 Marymount Hospital community:

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

Other Community Resources

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

- Donations and Volunteering
- Education, Recreation, and the Arts
- Employment and Income Support
- Family Support and Parenting

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

- 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 Marymount 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. Marymount 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

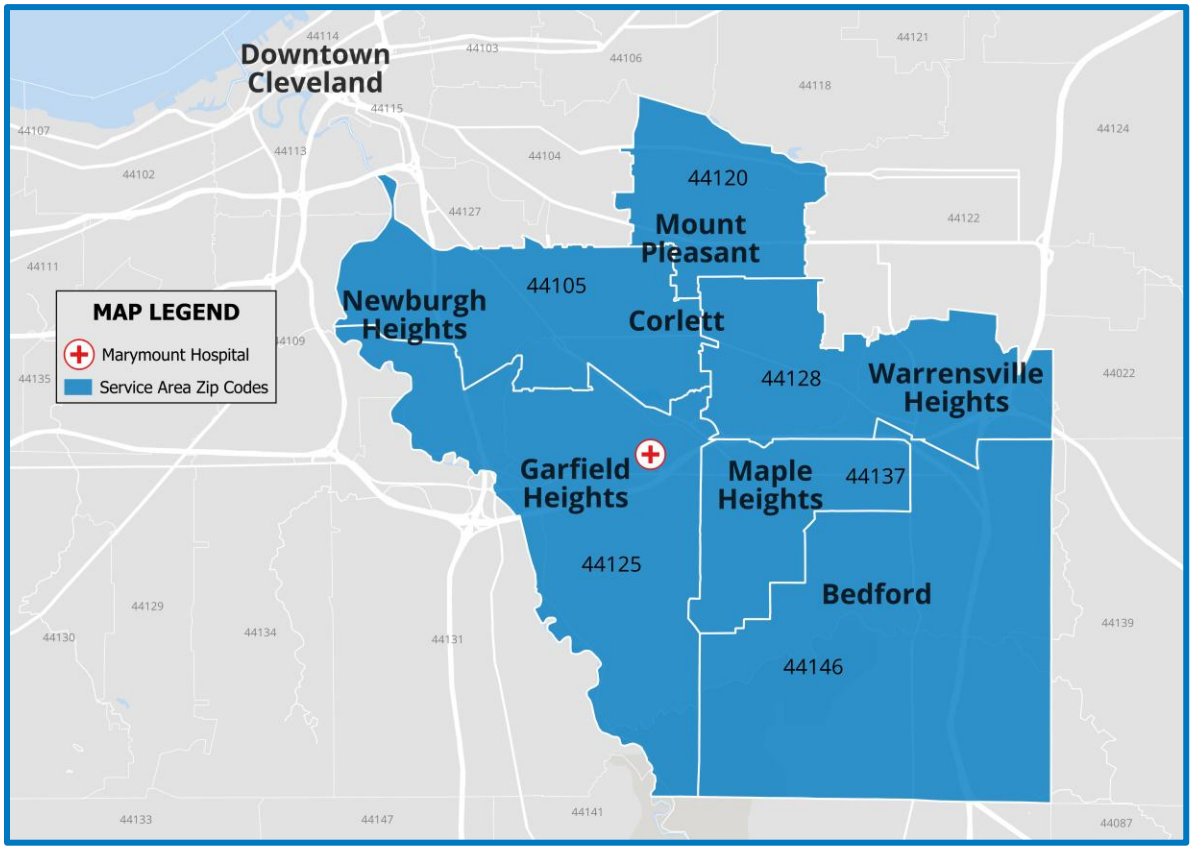
An overview of progress made on the 2022 Implementation Strategies.

F. Acknowledgements

Appendix A: Marymount Hospital Community Definition

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

Figure 9: Marymount 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.

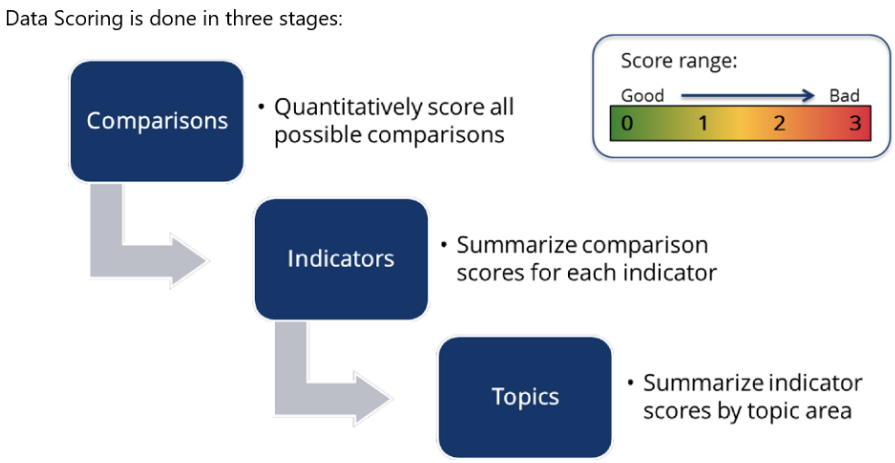
The following is a list of both local and national sources used in the Marymount Hospital Community Health Needs Assessment:

- 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 Dept. of Health, Infectious Diseases
- Ohio Dept. of Health, Vital Statistics
- Ohio Dept. of Health's Ohio Healthy Homes Lead Poisoning Prevention Program
- Ohio Department of Public Safety, Office of Criminal Justice Services
- Ohio Public Health Information Warehouse
- Ohio Secretary of State
- Prevention Research Center for Healthy Neighborhoods
- Purdue Center for Regional Development
- The Ohio Pregnancy Assessment Survey (OPAS) Dashboard
- U.S. Bureau of Labor Statistics
- U.S. Census - County Business Patterns
- U.S. Census Bureau - Small Area Health Insurance Estimates
- U.S. Environmental Protection Agency
- United For ALICE

Secondary Data Scoring

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

Figure 10: Summary of Topic Scoring Analysis



For the purposes of the Marymount 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 nationwide 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 comparison scores included. If none of the included comparison types are possible for an indicator, no score is calculated, and the indicator is excluded from the data scoring results. A full list of indicators and their scores can be found below.

Topic Scoring

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

Figure 11: Health and Quality of Life Topic Areas



Topics that received a score of 1.50 or higher were considered a significant health need. Eight health topics and all four quality of life topics scored at or above this threshold in Cuyahoga County (see Tables 2 and 3). The highest scoring health topic was *Sexually Transmitted Infections* with a score of 2.04.

Topic Scores

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

Table 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 Marymount Hospital community.

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

Zip Code	CHI Value	FII Value	MHI Value
44105	96.5	97.7	99.7
44120	57.1	87.9	98.7
44125	86.9	97.2	99.7
44128	86.9	97.2	99.7
44137	72.9	91.2	97.4
44146	25.3	71.7	97.2

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 Marymount Hospital Community.

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

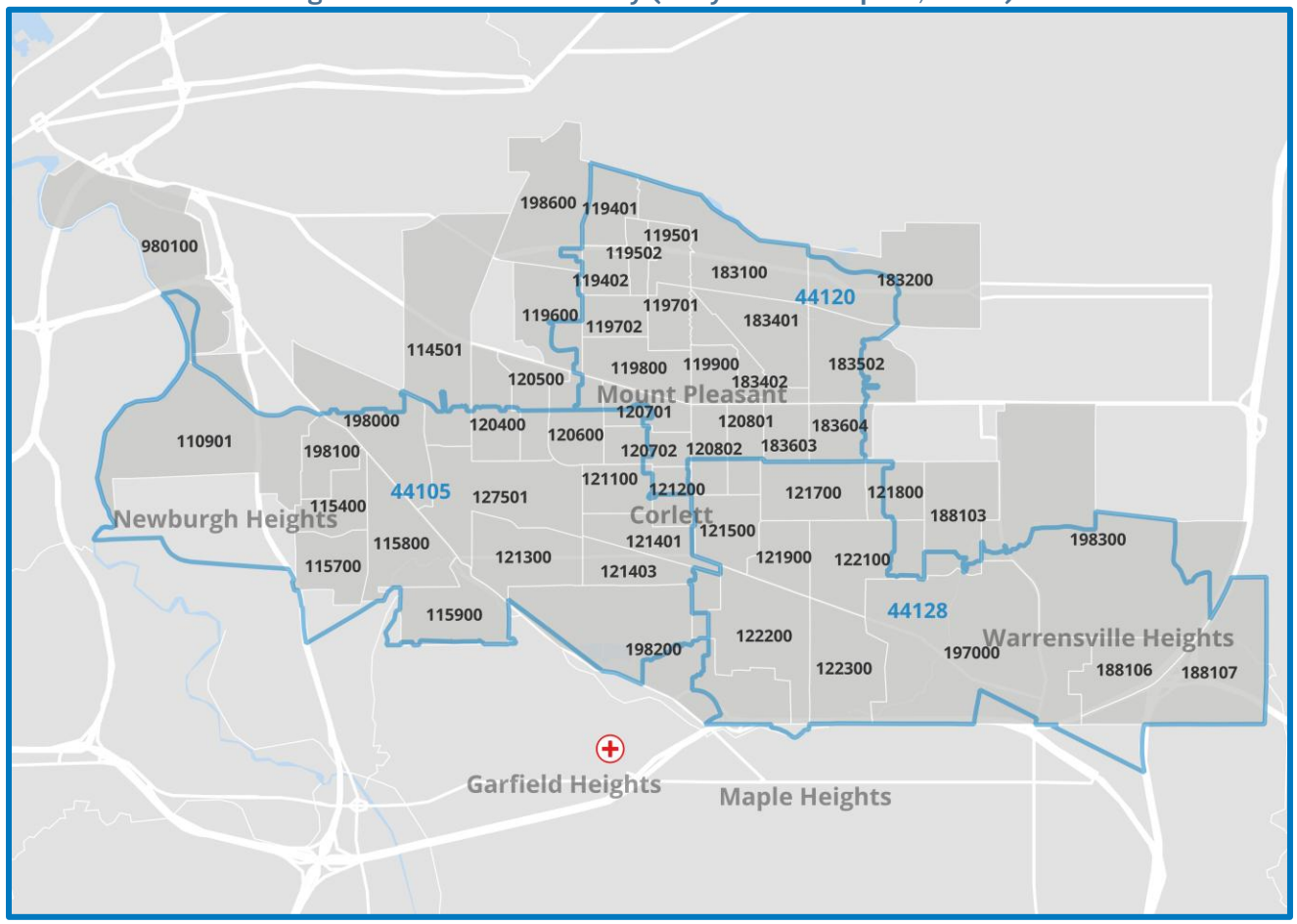


Table 5: Census Tracts by Zip Code (Marymount Hospital, North)

44105	44120	44128
110901	119401	120702
114501	119402	120801
115400	119501	120802
115700	119502	121200
115800	119600	121401
115900	119701	121403
120400	119702	121500
120500	119800	121700
120600	119900	121800
120701	120600	121900
120702	120701	122100
121100	120702	122200
121200	120801	122300
121300	120802	133103
121401	121100	133104
121403	121200	171103
127501	121700	183603
154200	183100	183604
154400	183200	188103
196100	183401	188106
198000	183402	188107
198100	183502	197000
198200	183603	197100
980100	183604	198200
	183605	198300
	198600	

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

Figure 13: Census Tract Key (Marymount Hospital, South)

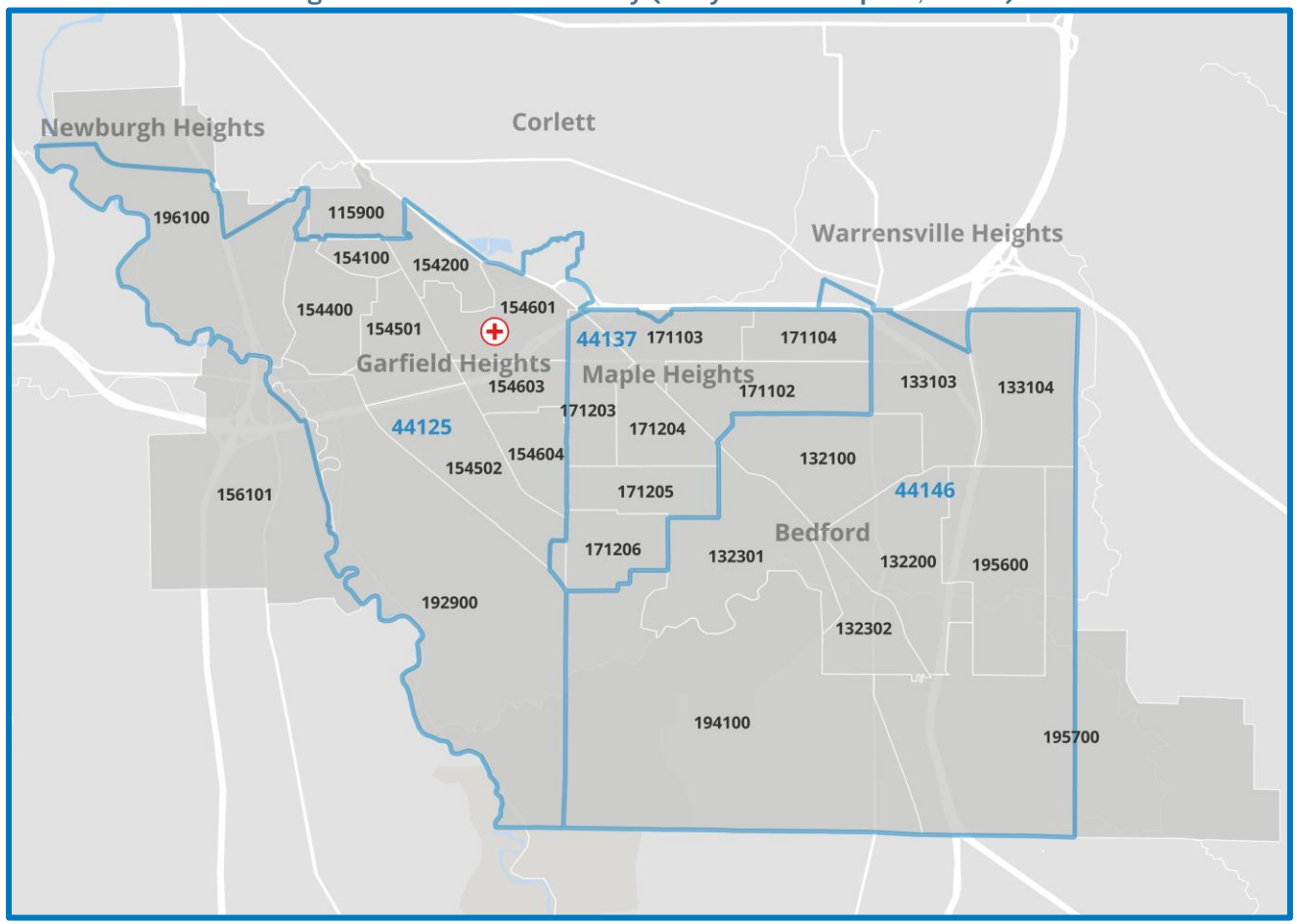


Table 6: Census Tracts by Zip Code (Marymount Hospital, South)

44125	44137	44146
115900	184103	132100
154100	184104	132200
154200	184105	132301
154400	184106	133103
154501	184108	133104
154502	195700	141206
154601	195800	171206
154603		194100
154604		195600
156101		195700
171103		197000
171203		
192900		
194100		
196100		
198200		

Community Health Index (CHI)

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

HOW IS THE INDEX VALUE CALCULATED?

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

WHAT DO THE RANKS AND COLORS MEAN?

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

Food Insecurity Index (FII)

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

HOW IS THE INDEX VALUE CALCULATED?

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

WHAT DO THE RANKS AND COLORS MEAN?

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

Mental Health Index (MHI)

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

HOW IS THE INDEX VALUE CALCULATED?

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

WHAT DO THE RANKS AND COLORS MEAN?

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

Data Considerations

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

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

Race or Ethnic and Special Population Groupings

The secondary data presented in this report derive from multiple sources, which may present 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 7 describes how to interpret the icons used to describe county distributions and trend data.

Table 7: Icon Legend

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

Indicators of Concern: Access to Healthcare

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

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

Indicators of Concern: Behavioral Health

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

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

Indicators of Concern: Chronic Disease Prevention and Management

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

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

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

Indicators of Concern: Maternal and Child Health

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

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

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

Indicators of Concern: Health-Related Social Needs

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

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

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

2.21	Vocational, Technical, and Other School Tuition Spending-to-Income Ratio	*percent*	1.8	--	1.6	1.6			--
2.21	Student-to-Teacher Ratio	*students/ teacher*	16.9	--	16.6	15.2			
2.18	Linguistic Isolation	*percent*	2.7	--	1.5	4.2			
2.18	Food Insecurity Rate	*percent*	15.1	--	14.1	13.5			
2.12	Median Household Gross Rent	*dollars*	1,005	--	988	1,348			
2.12	Mortgaged Owners Median Monthly Household Costs	*dollars*	1,529	--	1,472	1,902			
2.12	Adults with Disability Living in Poverty	*percent*	33.1	--	28.2	24.6			
2.12	Households that Used Check Cashing, Cash Advance, or Title Loan Shops	*percent*	2.3	--	2.0	2.0			
2.03	Households Living Below Poverty Level	*percent*	16.7	--	14.0	--		--	
2.03	Utilities Spending-to-Income Ratio	*percent*	6.7	--	6.2	5.8			--
2.00	Voter Turnout: Presidential Election	*percent*	65.7	58.4	71.7	--		--	
2.00	Renters Spending 30% or More of Household Income on Rent	*percent*	47.5	25.5	45.1	50.4			

All Indicator Scores by Topic Area

Below is a complete list of all indicators that were scored as part of the secondary data analysis. Indicators are grouped under their respective health and quality of life topic areas and include information about both the indicator data source and measurement period. Please refer to Table 8 below as a reference key for indicator data sources.

Table 8: 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 9: All Cuyahoga County Secondary Data Indicators

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Additional Demographic Data

The following tables detail the demographic, social, and economic characteristics of the Marymount 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 10: Population Size of Hospital Community by Zip Code

Zip Code	Population
44105	32,344
44120	33,198
44125	28,805
44128	26,872
44137	23,002
44146	29,305
Marymount Hospital Community (Total)	173,526

Table 11: Age Profile of Hospital Community and Surrounding Geographies

Age Category	Marymount Hospital Community	Cuyahoga County	Ohio
0-4	5.6%	5.2%	5.6%
5-9	5.8%	5.4%	5.7%
10-14	6.4%	5.6%	6.1%
15-17	3.9%	3.5%	3.8%
18-20	3.7%	3.9%	4.4%
21-24	4.5%	4.8%	5.3%
25-34	12.3%	13.5%	12.4%
35-44	12.2%	12.7%	12.2%
45-54	11.2%	11.2%	11.7%
55-64	13.5%	13.2%	13.0%
65-74	12.1%	12.1%	11.6%
75-84	6.0%	6.2%	6.1%
85+	2.6%	2.6%	2.2%
Median Age	41.4 years	41.4 years	40.5 years

Table 12: Racial/Ethnic Profile of Hospital Community and Surrounding Geographies

	Marymount Hospital Community	Cuyahoga County	Ohio	U.S.
White	22.2%	57.3%	75.7%	63.4%
Black/African American	70.0%	29.2%	12.8%	12.4%
American Indian/Alaskan Native	0.2%	0.2%	0.3%	0.9%
Asian	1.1%	3.6%	2.7%	5.8%
Native Hawaiian/Pacific Islander	0.0%	0.0%	0.1%	0.2%
Another Race	1.8%	3.1%	2.1%	6.6%
Two or More Races	4.8%	6.5%	6.4%	10.7%
Hispanic or Latino (any race)	3.8%	7.3%	5.0%	19.0%

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

Table 13: Population Age 5+ by Language Spoken at Home for Hospital Community and Surrounding Geographies

	Marymount Hospital Community	Cuyahoga County	Ohio	U.S.
Only English	95.2%	88.5%	92.8%	78.0%
Spanish	2.2%	4.3%	2.3%	13.4%
Asian/Pacific Islander Language	0.4%	1.5%	1.0%	3.5%
Indo-European Language	1.5%	4.3%	2.8%	3.8%
Other Language	0.7%	1.5%	1.1%	1.2%

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

Table 14: Household Income of Hospital Community and Surrounding Geographies

Income Category	Marymount Hospital Community	Cuyahoga County	Ohio
Under $15,000	16.3%	12.8%	9.5%
$15,000 - $24,999	11.5%	9.1%	7.8%
$25,000 - $34,999	10.8%	8.7%	8.0%
$35,000 - $49,999	15.3%	12.5%	12.2%
$50,000 - $74,999	18.2%	16.5%	17.0%
$75,000 - $99,999	10.9%	11.9%	13.0%
$100,000 - $124,999	6.5%	8.4%	9.9%
$125,000 - $149,999	4.1%	5.8%	7.0%
$150,000 - $199,999	3.4%	6.2%	7.2%
$200,000 - $249,999	1.3%	3.0%	3.5%
$250,000 - $499,999	1.2%	3.4%	3.4%
$500,000+	0.6%	1.7%	1.6%
Median Household Income	$46,471	$60,568	$68,488

Table 15: Poverty Rates in Hospital Community and Surrounding Geographies

	Families Below Poverty
Marymount Hospital Community	18.0%
Cuyahoga County	12.2%
Ohio	9.4%
U.S.	8.8%
Marymount Hospital Zip Codes	.
44105	26.1%
44120	16.8%
44125	15.2%
44128	21.9%
44137	20.1%
44146	8.3%

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

Table 16: Educational Attainment of Hospital Community and Surrounding Geographies

	Marymount Hospital Community	Cuyahoga County	Ohio	U.S.
Less than High School Graduate	11.0%	9.3%	8.6%	10.6%
High School Graduate	34.3%	27.2%	32.8%	26.2%
Some College, No Degree	24.2%	20.4%	19.6%	19.4%
Associate Degree	10.1%	8.3%	8.9%	8.8%
Bachelor's Degree	12.2%	20.4%	18.6%	21.3%
Master's, Doctorate, or Professional Degree	8.3%	14.4%	11.5%	13.7%

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

Table 17: 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%
Marymount Hospital Zip Codes	.
44105	56.1%
44120	48.5%
44125	59.6%
44128	54.9%
44137	45.6%
44146	47.8%

All values: American Community Survey (2019-2023)

Table 18: Internet Access in Hospital Community and Surrounding Geographies

	Households with Internet
Cuyahoga County	87.5%
Ohio	89.0%
U.S.	89.9%
Marymount Hospital Zip Codes	.
44105	56.1%
44120	48.5%
44125	59.6%
44128	54.9%
44137	45.6%
44146	47.8%

All values: American Community Survey (2019-2023)

Appendix C: Environmental Scan and Key Findings

An environmental scan was conducted to supplement quantitative data and further contextualize health needs across Cuyahoga County. This scan involved a review of recent community health assessments, needs reports, and partner studies across healthcare, public health, and social service sectors. Findings from local efforts, including reports from the United Way, hospital systems, and regional health collaboratives, corroborated the relevance of the five prioritized needs in this 2025 CHNA process for Marymount 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 different 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 (Collaborating Organizations: University Hospital, Cuyahoga County Board of Health, and the City of Cleveland Department of Health)[21]
- 2023 Livable Cuyahoga Needs Assessment[22]

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[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 health equity? (Health equity is the idea that everyone should have the same chance to be healthy, regardless of their circumstances)**

- **What are some possible solutions to the problems that we have discussed?**
  - How can 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 the 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

Community stakeholders from a total of 18 organizations provided feedback specifically for the Marymount 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 Marymount 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
- LGBTQ+ Assessment Greater Cleveland / Cleveland Clinic
- Lead Safe Cleveland Coalition
- Maple Heights City School District
- NAMI Greater Cleveland
- Union Miles Development Corporation
- University Settlement

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

Access to Healthcare

Stakeholder interviews conducted for the Marymount Hospital 2025 CHNA revealed persistent challenges in ensuring equitable Access to Healthcare across the community. Participants described a range of barriers that limit residents' ability to obtain timely, affordable, and appropriate services, with issues especially pronounced for low-income households, older adults, and racially and ethnically diverse populations. Transportation challenges, high out-of-pocket costs, limited availability of culturally and linguistically responsive care, and difficulties navigating a complex healthcare system were among the most frequently cited concerns. Even when residents have insurance, many struggle to

afford medications, follow-up appointments, or specialty care, leading to delayed treatment and reliance on emergency departments for primary needs.

Stakeholders emphasized the importance of developing integrated care models, such as co-located medical, behavioral, and social services, and expanding mobile clinics and telehealth to bring care directly into neighborhoods. Trust between patients and providers was seen as essential for encouraging engagement, particularly for populations that have historically faced systemic challenges in healthcare. Participants also highlighted shortages in primary care, specialty care, and preventive services, pointing to long wait times and fragmented delivery as barriers that worsen health outcomes. Addressing these access issues, they stressed, will require not only improved coordination of healthcare services but also targeted efforts to reduce financial and logistical burdens and to strengthen community trust in the healthcare system.

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

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

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

Transportation as a Barrier

"If you don't have a car, getting to an appointment can take hours. Public transit is limited, and it doesn't always go near the clinics people need."

Affordability and Insurance Limitations

"Even people with insurance are struggling because the co-pays, prescriptions, and follow-up visits are too expensive. It forces families to choose between bills and their health."

System Complexity and Delays

"The system is so confusing that people just give up. They don't know who to call, or they get put on a waitlist for months."

Culturally and Linguistically Responsive Care

"There's not enough care that feels welcoming for everyone. If you don't speak English or your culture isn't understood, you're less likely to go back for care."

Emergency Department Reliance

"A lot of people wait until things get so bad they end up in the ER. That's not because they want to—it's because they don't have another option."

Community input reaffirmed that access to quality, affordable healthcare is a pressing and multifaceted issue for the Marymount Hospital community. Residents face compounding barriers, including cost, distance, limited provider availability, and lack of culturally informed services, which affect their ability to engage in preventive care and manage chronic conditions. For historically marginalized communities, the absence of trust and continuity further exacerbates health inequities. 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

Stakeholder feedback revealed that Behavioral Health, encompassing both Mental Health and Substance Use Disorder, remains a deeply entrenched concern in the Marymount Hospital community, affecting residents of all ages. Participants noted that these challenges have been magnified in recent years by the prolonged effects of the COVID-19 pandemic, coupled with social isolation, trauma, and ongoing economic pressures. Mental health and substance use concerns were closely linked to broader community conditions such as housing instability, poverty, and lack of social support, which both trigger and intensify behavioral health needs. Youth mental health was frequently emphasized, with stakeholders citing rising rates of anxiety, depression, and trauma-related concerns, compounded by long wait times and limited pediatric behavioral health providers. Substance Use, particularly opioids, was highlighted as a persistent issue requiring stronger prevention and recovery supports.

Access to Care was identified as a consistent barrier, driven by provider shortages, long delays for appointments, limited crisis intervention options, and a lack of culturally and linguistically responsive services. Several participants also underscored the ongoing stigma associated with seeking treatment, which discourages individuals from pursuing care. Stakeholders stressed the importance of expanding integrated care models, school-based supports, and mobile or community-based behavioral health services to meet residents where they are. Building capacity for crisis response, strengthening prevention, and ensuring continuity of care across the treatment spectrum were described as critical next steps to address the community's behavioral health needs effectively.

The following are highlights of participant feedback regarding behavioral health:

- Increased mental health needs post-pandemic: Anxiety, depression, and trauma-related concerns have become more prevalent across all age groups, especially among youth and older adults.

- Persistent provider shortages: Stakeholders highlighted long wait times and a lack of behavioral health professionals as major access issues.
- Substance misuse, particularly opioids and fentanyl, is a growing crisis: There is an urgent need for expanded prevention, treatment, and harm reduction efforts.
- Limited culturally competent behavioral health services: Language barriers and lack of culturally sensitive care discourage engagement in mental health or addiction services.
- Stigma continues to be a barrier: Fear of judgment prevents individuals from seeking help for both mental health and substance use.
- Need for school-based and community-centered support: Participants emphasized the value of meeting individuals where they are, particularly through trusted local institutions.

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

Behavioral Health Access & Provider Shortages

"We simply don't have enough behavioral health providers to meet the demand, especially for youth and older adults."

"It takes weeks, sometimes months, to get an appointment with a qualified mental health provider, which discourages people from seeking help."

Stigma and Cultural Responsiveness

"Stigma still keeps a lot of people from asking for help, especially in certain cultural groups."

"There's not enough culturally or linguistically appropriate care, so people often don't feel understood or supported."

Youth Mental Health

"Our young people are struggling with depression and anxiety, and there just aren't enough school or community-based resources to support them."

"COVID really amplified the isolation and stress for kids, and we're still seeing those effects."

Substance Use & Crisis Response

"Substance use is a huge concern here, but we don't have enough crisis intervention options—people end up in the ER or jail instead of treatment."

"We need more integrated approaches that deal with both mental health and substance use together, not in silos."

Stakeholders reinforced that behavioral health is a foundational component of overall health and community wellbeing. The need for expanded, integrated, and culturally

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

Chronic Disease Prevention & Management

Stakeholder discussions emphasized that chronic diseases such as diabetes, hypertension, heart disease, obesity, and dementia are pressing issues in the Marymount Hospital community. Respondents highlighted the interconnected role of nutrition, stress, and preventive supports in shaping outcomes. Poor food access, limited opportunities for physical activity, and inadequate supports for stress reduction were seen as major drivers of chronic conditions. Several participants noted that these issues are compounded by social isolation among older adults, and that dementia and Alzheimer's care remain under-recognized needs.

Stakeholders also stressed that barriers to prevention and consistent management extend beyond clinical care. Transportation challenges, fragmented access to clinics, and lack of community-based resources were noted as obstacles for maintaining treatment and engaging in preventive care. Many emphasized that chronic disease efforts must not only focus on education and screening but also create environments that make healthy choices practical and sustainable—such as access to safe places for physical activity, community gardens, or local senior centers.

Importantly, participants observed cultural and behavioral barriers, including a sense of fatalism in some neighborhoods where high rates of diabetes or obesity are viewed as inevitable. This was described as a significant hurdle for engaging residents in screenings or prevention programs, with some individuals reluctant to participate until their condition had already advanced.

Overall, stakeholders called for a holistic, community-centered strategy that integrates health education, early screening, navigation supports, and neighborhood-based resources. Tailored approaches for older adults, underserved populations, and communities experiencing long-term disinvestment were seen as essential to reducing chronic disease burden and supporting long-term wellness.

Nutrition & Healthy Eating and Wellness & Lifestyle
The following are highlights of participant feedback regarding nutrition and healthy eating and wellness and lifestyle:

- Residents in lower-income neighborhoods face limited access to affordable, nutritious foods and fresh produce.
- Poor dietary choices are often driven by lack of education, time, or resources rather than lack of interest in healthy eating.

- There is a desire for more community gardens, farmers markets, and culturally appropriate wellness education.
- Stakeholders noted the need for physical activity programs and recreational spaces that are safe, accessible, and affordable.

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

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

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

Cancer
The following are highlights of participant feedback regarding cancer:

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

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

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

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

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

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

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

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

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

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

Older Adult Health

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

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

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

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

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

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

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

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

Maternal and Child Health

The following highlights key insights from stakeholder interviews regarding maternal and child health in the community Marymount Hospital serves. Participants consistently raised concerns about differences in maternal care, shortages of OB/GYN and pediatric providers, and barriers created by reimbursement structures that limit access to preventive and supportive services such as doulas and centering programs. Stakeholders also pointed to rising adolescent health challenges, particularly mental health issues, reproductive health needs, and obesity linked to food insecurity and limited opportunities for physical activity. These concerns are shaped by broader systemic issues, including Medicaid acceptance, insurance restrictions, and a shortage of culturally competent, family-centered providers. Stakeholders emphasized the importance of coordinated, family-focused care that extends across prenatal, postpartum, pediatric, and adolescent stages, with stronger investments in prevention, equitable reimbursement, and community-based youth development supports.

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

Maternal, Fetal & Infant Health

- Access to prenatal care remains inconsistent, especially for uninsured or underinsured individuals.
- Transportation, housing instability, and mental health concerns complicate pregnancy and postpartum health.
- Participants identified a need for wraparound services such as doulas, home visiting programs, and peer support.
- Postpartum depression and anxiety are underdiagnosed and undertreated due to stigma and limited behavioral health access.

Children's Health

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

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

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

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

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

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

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

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

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

In summary, stakeholders reinforced that maternal and child health is a critical focus area that requires early intervention, consistent care, and community-based support. Addressing the social and structural barriers that affect pregnancy, birth outcomes, and child development is essential to improving health equity in the Marymount Hospital community. From mental health services to nutrition and education, families need access to trusted providers and systems that are responsive to their lived realities. Investing in maternal and child health not only improves individual outcomes but also strengthens the long-term wellbeing of the entire community.

Health-Related Social Needs

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

Prevention & Safety

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

Quality of Life (Community, Economy, Education)

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

Community Infrastructure and Engagement

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

Economic Opportunity and Stability

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

Education as Foundation for Well-being

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

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

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

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

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

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

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

Appendix E: Impact Evaluation

Actions Taken Since Previous CHNA

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

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

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

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

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

Behavioral Health

Actions and Highlighted Impacts:

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

B. 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.

C. Marymount hospital donated 200 Deterra Pouches to Valley View Fire Department, for distribution to community residents. Pouches were also distributed during events at Maple Heights Senior Center and University Settlement.

D. Partnered with Ohio Guidestone who provided in-service for school staff related to de-escalation in the classroom, and taking care of mental health issues.

Chronic Disease Prevention and Management

Actions and Highlighted Impacts:

A. Stroke Education was provided to community residents at the library and local senior centers. Taussig Cancer Community Outreach team offered resource education. A Mammogram Clinic was provided in May 2024. Lung cancer and colon cancer screenings were provided.

B. Marymount Hospital provided community education regarding sepsis prevention. Education was provided to the Jennings Nursing Home nursing team on stroke and sepsis for increased resident awareness.

Maternal and Child Health

Actions and Highlighted Impacts:

A. Cleveland Clinic continued to participate in First Year Cleveland and the Cuyahoga County Infant Mortality Task Forces to gather data, align programs, and coordinate a systemic approach to improving infant mortality. Supported expanded evidence-based health education to expecting mothers and families.

B. Through Cleveland Clinic's Center for Infant and Maternal Health, the hospital continued to provide services for at-risk pregnant women to improve their health and support babies reaching their first birthday. Cleveland Clinic's Community Health Workers (CHWs) provided education on safe sleep, diet, nutrition, and screened for social drivers of health. CHWs connected families

to resources and reinforced healthcare access. If eligible, mothers received food vouchers.

C. The hospital continued to support the *Centering Pregnancy* group prenatal care model to expecting mothers and increased the number of families who participate in evidence-based home visiting programs.

Health-Related Social Needs

Actions and Highlighted Impacts:

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

B. Marymount Hospital partnered with community-based organizations to host food drives and volunteer at food banks to improve access to healthy foods. The hospital partnered with the Greater Cleveland Food Bank to improve access to healthy foods, serving over 3,000 households.

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 children across Northeast Ohio. This initiative is part of Cleveland Clinic's larger $10.4 million commitment to addressing food insecurity across our communities by helping families access the resources they need to thrive.

D. Marymount Hospital engaged students from Garfield Heights City Schools to experience workforce development and training opportunities for youth K-12 in clinical and non-clinical areas, empowering Northeast Ohio's next generation of leaders. The hospital also hosted tours and career fairs.

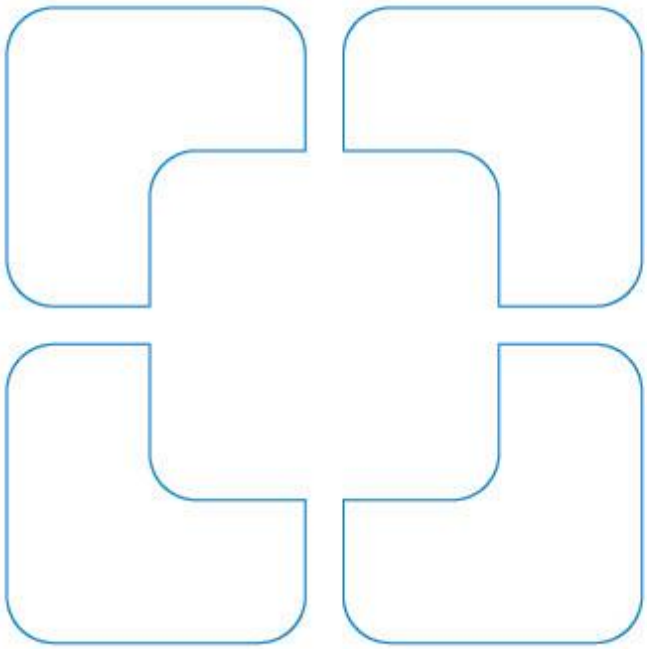
E. Cleveland Clinic's Center for Youth and College Education provided youth and college learners with career exploration opportunities in a healthcare environment, offering programming that prepares the next generation of caregivers to join the healthcare workforce.

Appendix F: Acknowledgements

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

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Cleveland Clinic
Marymount Hospital

Implementation Strategy Report

2025

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

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Marymount 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 Marymount 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 Marymount 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

Marymount Hospital, a 263 bed[23] acute care teaching hospital within the Cleveland Clinic health system, has served southern and southeastern Cuyahoga County since its founding in 1949 by the Sisters of St. Joseph of the Third Order of St. Francis. As the first community hospital to join Cleveland Clinic in 1995, the hospital provides a full continuum of services including emergency care, surgery, specialty programs, acute and sub-acute care, and outpatient rehabilitation. The hospital is also recognized for its leading orthopedic, endocrine, and behavioral health programs.

As part of the broader Cleveland Clinic health system, Marymount 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

[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.

professionals. Currently, with more than 83,000 caregivers, 23 hospitals, and 280 outpatient facilities around the world, Cleveland Clinic is recognized as one of the world's leading healthcare systems. Its collaborative, patient-centered model of care promotes improved outcomes and enhances quality of life for patients both locally and internationally.

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

Marymount 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 health equity. 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, Marymount 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.

Marymount 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/marymount-hospital.

II. Marymount Hospital Community Definition

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

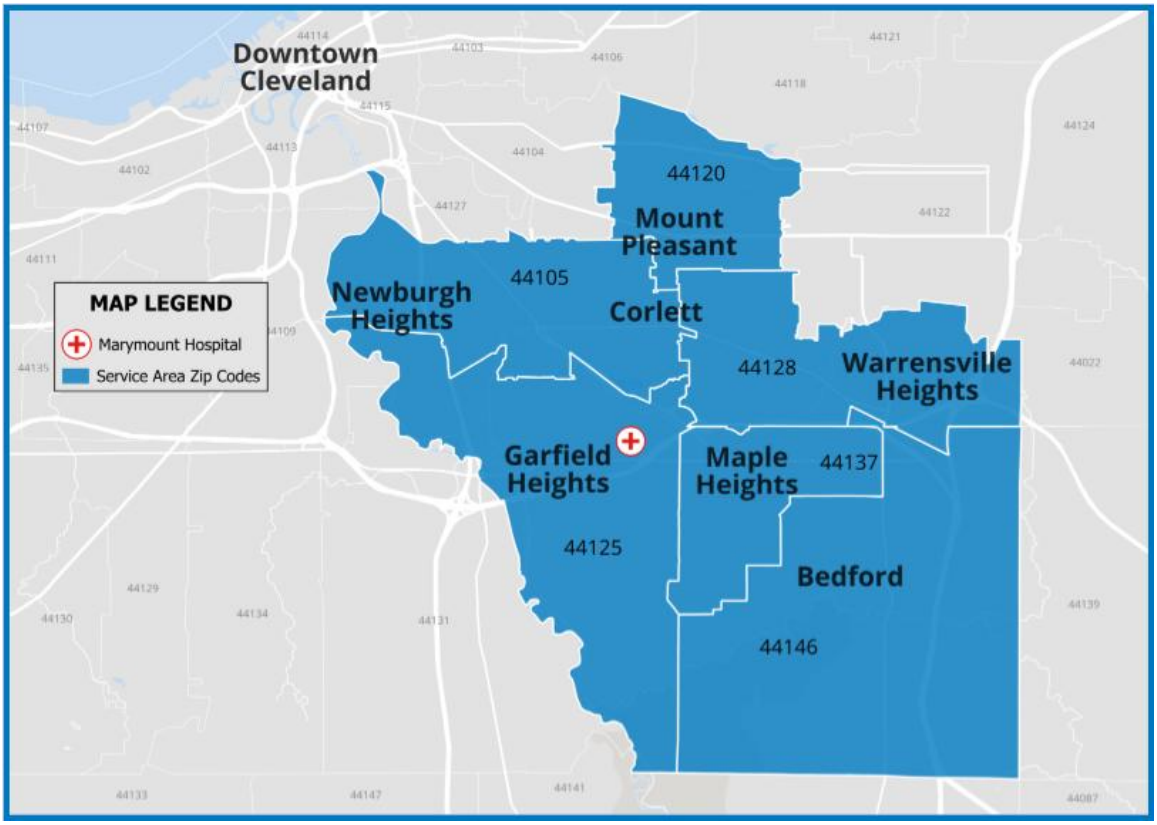


Table 1: Marymount Hospital Community Definition

Zip Code	Postal Name
44105	Newburgh Heights
44120	Mount Pleasant
44125	Garfield Heights
44128	Warrensville Heights
44137	Maple Heights
44146	Bedford

III. How Implementation Strategy was Developed

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

Marymount 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 Marymount 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 Marymount 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 Marymount Hospital identifies Access to Healthcare as a significant challenge, with affordability, transportation barriers, and provider shortages disproportionately affecting certain populations. Stakeholders noted that high out-of-pocket costs, limited prescription coverage, and long wait times discourage timely care, while behavioral health and pediatric services remain major unmet needs. Systemic issues, including fragmented services, limited culturally and linguistically appropriate

care, and digital navigation challenges, further hinder access, especially for older adults. Secondary data reinforce these concerns, showing low rates of regular checkups and insurance coverage, high preventable hospitalization rates, particularly among Black Medicare recipients, and elevated Community Health Index scores, indicating concentrated access barriers in neighborhoods such as 44105.

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.

B. Behavioral Health

The 2025 CHNA for Marymount Hospital identifies Behavioral Health as a critical priority, with stakeholders reporting widespread depression, anxiety, trauma, and chronic stress, often intensified by poverty, housing instability, and food insecurity. Some communities face amplified risks due to stigma, language barriers, and limited access to culturally responsive care. Provider shortages, long wait times, and fragmented coordination further hinder early intervention. Substance use disorder, especially involving opioids and fentanyl, was described as a worsening crisis requiring expanded treatment, harm-reduction strategies, and trauma-informed, community-based supports. Secondary data reinforce these concerns, showing declining mental health, high drug poisoning and alcohol-related death rates, and Mental Health Index scores above 90 across all Marymount zip codes, indicating severe unmet behavioral health needs.

Behavioral Health Initiatives for 2026-2028 include:

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

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

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

C. Chronic Disease Prevention and Management 

The 2025 CHNA for Marymount Hospital identifies Chronic Disease Prevention and Management as a major concern, with high rates of diabetes, hypertension, cardiovascular disease, cancer, and kidney disease strongly influenced by poverty, food insecurity, and limited safe spaces for physical activity. Stakeholders noted that many residents face barriers such as affordability challenges, transportation limitations, fragmented care coordination, and insufficient access to specialists, leading to late diagnoses and poor management. Food deserts, limited wellness resources, and high stress further worsen outcomes, especially in low-income and diverse communities. Participants emphasized the need for culturally responsive care, expanded nutrition and wellness programs, improved screening access, and integrated support services. Secondary data show significant differences in health outcomes, particularly among Black/African American residents and older adults, underscoring the need for prevention-focused, community-driven solutions.

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:** Launch new hospital Community Resource Center, offer classes on health and community resources.

   Anticipated Impacts: Improve physical activity, improve nutrition, increase health and financial literacy, improve access to social services and assistance programs.

D. Maternal and Child Health 

The 2025 CHNA for Marymount Hospital identifies Maternal and Child Health as a major priority due to persistent differences linked to social, economic, and systemic barriers. Stakeholders emphasized limited access to comprehensive prenatal and postpartum care, transportation challenges, unstable housing, and inconsistent insurance coverage, factors that disproportionately affect low-income women and women of color. They

stressed the need for culturally responsive supports such as doulas, peer networks, and integrated perinatal mental health services. Children's health concerns included rising behavioral health needs, provider shortages, long wait times, and gaps in developmental and preventive care. Secondary data reinforce these challenges, showing high child mortality, elevated preterm and low-birthweight rates, and increased risks such as lead exposure, youth disconnection, and violent crime across Cuyahoga County.

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 Marymount Hospital identifies Health-Related Social Needs as a foundational driver of health, influencing outcomes across chronic disease, behavioral health, maternal and child health, and access to care. Stakeholders emphasized how income instability, housing affordability, transportation barriers, and neighborhood safety restrict residents' ability to access services, maintain healthy behaviors, and manage stress, challenges that disproportionately affect low-income families, older adults, and communities of color. Food deserts limited recreational spaces, and differences in educational access further compound these burdens. Participants stressed the need for cross-sector collaboration, targeted investments in housing and transit, and community-driven strategies to dismantle systemic barriers. Secondary data reinforce these concerns, highlighting high financial strain, low median income, and education costs that exceed state and national averages.

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. Integrate hospital's food pantry and food distribution with school and community resources. Support key partnership with Greater Cleveland Food Bank.

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

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

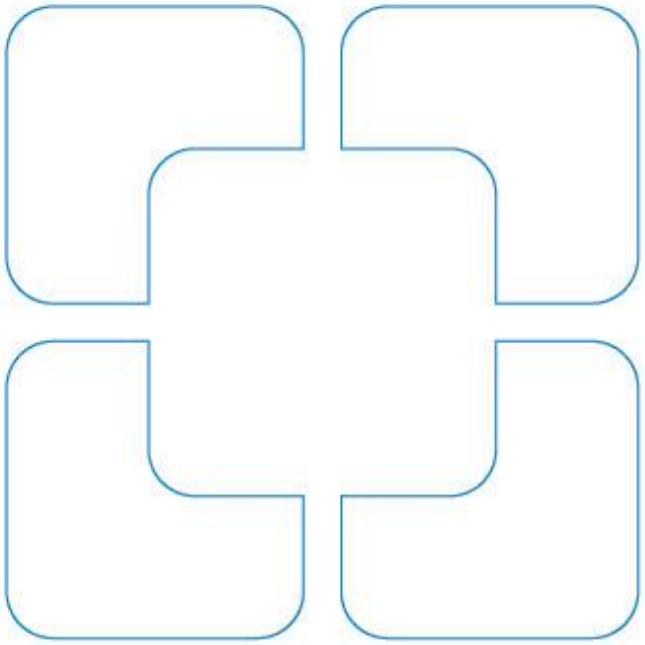
   Anticipated Impacts: Increase collaboration with community-based organizations, develop sustainable initiatives. Improve community awareness of available resources, develop a resource guide, and improve access to social supports.

D. **Initiative:** Provide workforce development and training opportunities for K-12 students, and adults, 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 Marymount 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 Marymount 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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