Cleveland Clinic
Mentor Hospital

Community Health Needs Assessment

2025

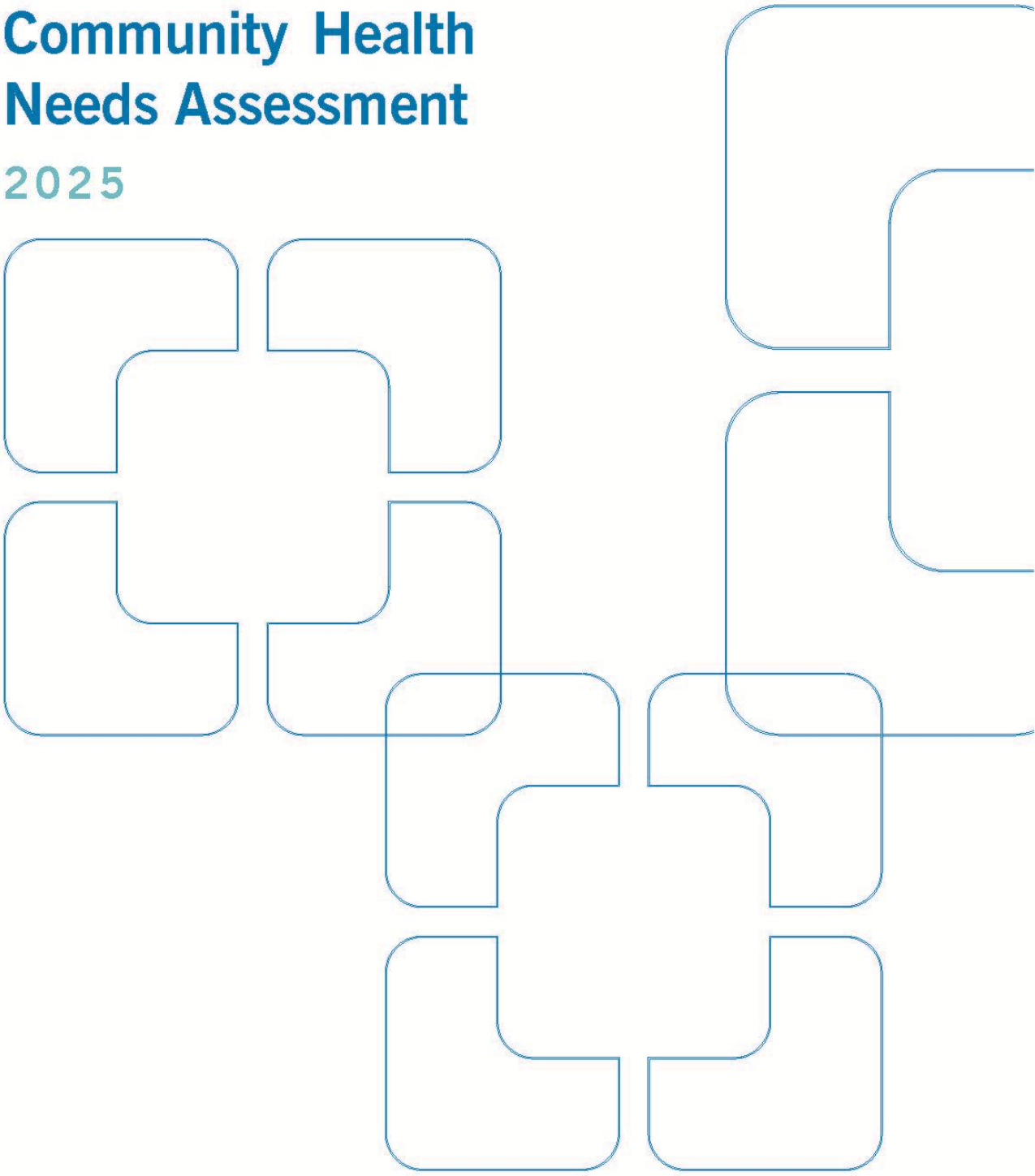


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Mentor Hospital 2025 Community Health Needs Assessment

Introduction

Mentor Hospital, a 34-bed[1] acute care facility within the Cleveland Clinic health system, opened in 2023 to expand access to high-quality care for Lake County residents. The hospital features four operating rooms and advanced telehealth technology that connects patients with Cleveland Clinic specialists across disciplines. The hospital offers a full continuum of inpatient, outpatient, surgical, and emergency services, along with recognized strengths in orthopedics and behavioral health.

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

Mentor 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. 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, Mentor 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.

Mentor 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/mentor-hospital.

[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.

CHNA Background

As part of its mission to improve health and well-being in the communities it serves, Mentor 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 and qualitative community feedback.

Mentor Hospital Community Definition

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

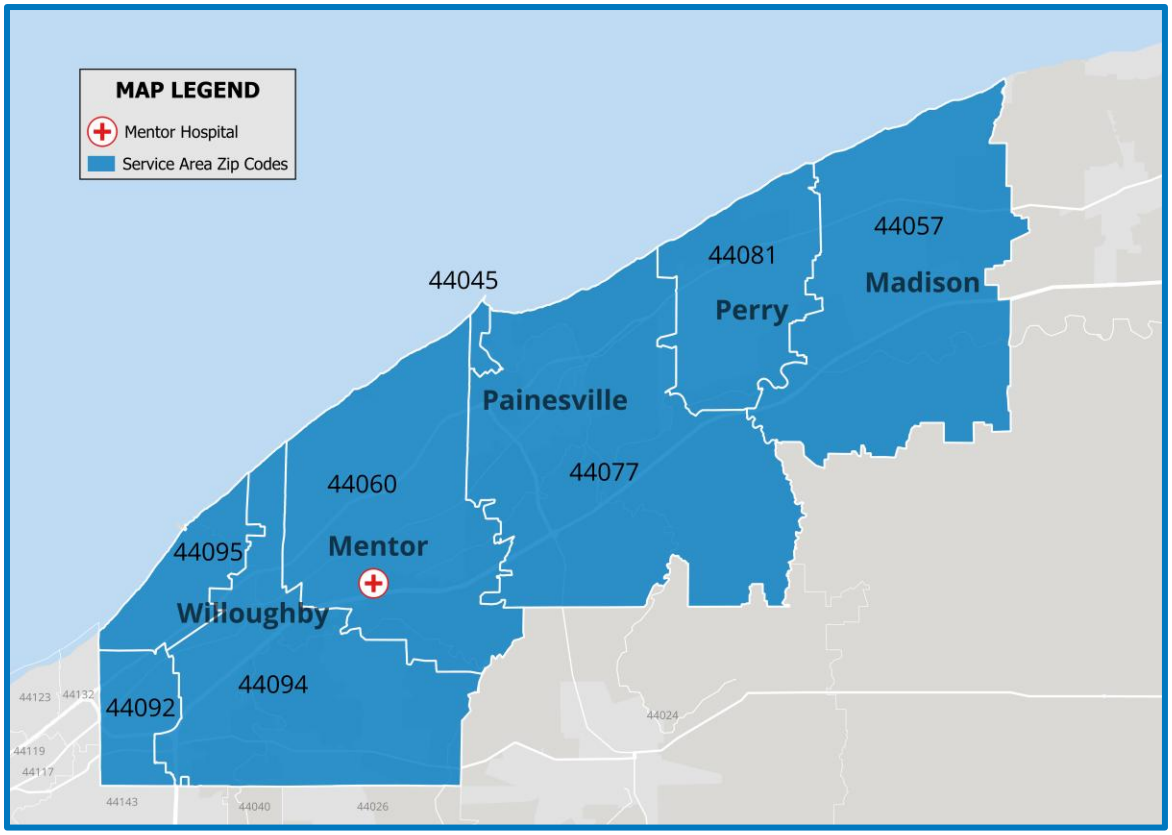


Table 1: Mentor Hospital Community Definition

Zip Code	Postal Name
44045	Grand River
44057	Madison
44060	Mentor
44077	Painesville
44081	Perry
44092	Wickliffe
44094	Willoughby
44095	Eastlake

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 Lake County level and within a defined 8-zip-code Mentor 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.

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 Mentor Hospital.

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

Primary Data Methodology and Key Findings

To ensure community priorities and lived experience were centered in this assessment, conversations were hosted with community stakeholders across the Mentor Hospital community. Community stakeholders from 13 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 care, gaps in behavioral health support, housing-related health risks, and challenges of 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

Mentor 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:

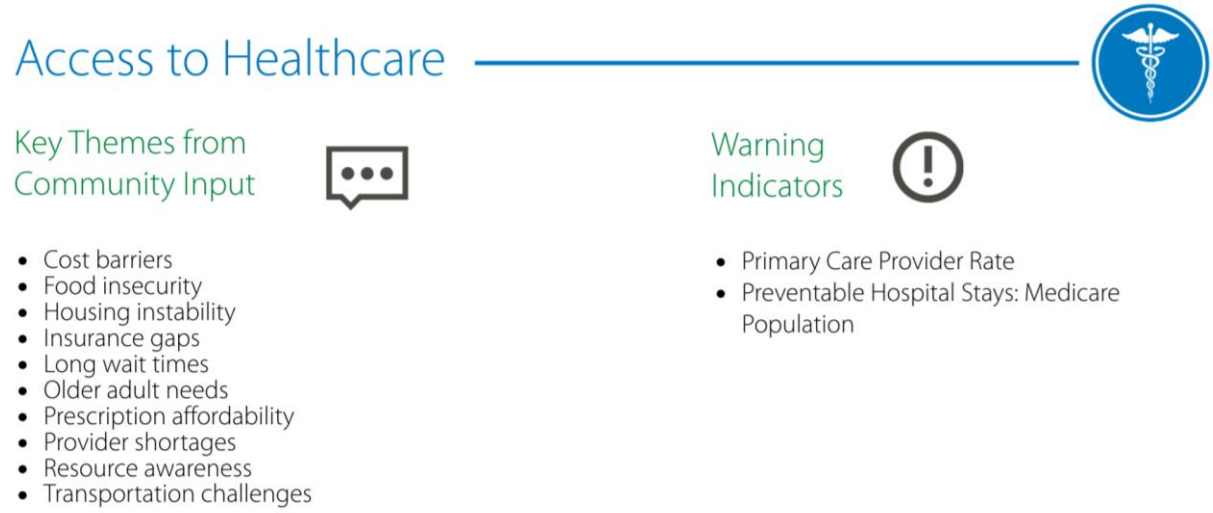


These priorities reflect persistent and deeply interconnected challenges, such as provider shortages, care affordability, mental health access, chronic disease burden, and the health impacts of poverty and neighborhood conditions. Community input, coupled with data showing that the hospital's defined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

The five prioritized community health needs identified in this 2025 Mentor 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 was identified as a pressing challenge for the Mentor Hospital community for the 2025 CHNA. Community feedback emphasized that access to healthcare is a significant challenge for many residents, particularly those who rely on Medicaid or have complex medical or behavioral health needs. Participants described persistent difficulties in securing appointments with specialists, such as neurologists and psychiatrists, due to a limited number of providers accepting Medicaid. This shortage often forces residents to travel outside Lake County for care, creating additional financial and logistical barriers. Transportation was also identified as a substantial obstacle, especially for families and individuals with limited mobility or who depend on paratransit services with restricted schedules.

Stakeholders noted that cost and coverage gaps continue to restrict access to necessary services. Families with low incomes, particularly those living in pockets of poverty within the community, often struggle to afford care despite insurance coverage. Interviewees highlighted the growing number of students qualifying for free and reduced lunch as an indicator of broader economic hardship that directly affects health access. Concerns were also raised about grandparents increasingly serving as primary caregivers, which places additional strain on older adults already managing their own health needs while navigating insurance and caring for younger dependents.

Despite these challenges, the community has shown resilience and collaboration in addressing needs. Local schools, United Way, and organizations such as the Salvation Army have partnered to expand food access and provide essential resources, recognizing the link between nutrition and health outcomes. However, these efforts were consistently described as insufficient compared to the scale of demand, with food distributions often depleted within hours. The shortage of nursing staff and healthcare workers further compounds access issues. Overall, the interviews underscored that improving transportation, expanding Medicaid-accepting providers, and supporting populations

such as low-income families and multi-generational households are critical priorities for advancing equal access to healthcare in Mentor.

Secondary data demonstrate high rates of hospital use for preventable issues across Lake County. Among the county's Medicare population, specifically, the county's rate of preventable hospital stays is about 25% higher than the national rate (3,544 vs. 2,769 per 100,000 Medicare recipients). This overreliance on hospital care may be driven by a low prevalence of primary care providers (41.4 providers per 100,000 county residents). This provider rate is lower than both state and national averages and has been in decline since 2015.

Conduent HCI's Community Health Index (CHI) estimates health risk based on health-related social needs and can help to identify areas where access to care is especially critical. Notably, all zip codes in the Mentor Hospital community have a CHI value below 50, indicating relatively lower levels of need, compared to other U.S. zip codes. However, within this community, the highest CHI value and greatest area of need is in the zip code 44057 (Madison), with an index value of 49.3. 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 more urgent and complex priorities for the Mentor Hospital community in the 2025 CHNA, particularly after the COVID-19 pandemic. Interviewees consistently emphasized rising rates of depression, anxiety, and difficulty coping with daily stressors across both youth and adult populations. Schools, employers, and families alike are struggling to manage these needs, with educators and community leaders reporting that students and employees require greater mental health support. Dual diagnoses, such as developmental disabilities combined with mental health challenges, were highlighted as particularly difficult to manage, placing significant strain on families and service providers. Additionally, concerns about substance use—especially youth vaping, tobacco, and marijuana, were identified as ongoing challenges requiring community-wide interventions.

While Lake County benefits from a network of providers such as Crossroads Health, Signature Health, and the Adams Board, several systemic challenges limit access to behavioral health care. Among these are long wait times, workforce shortages, and funding constraints that make it difficult to sustain consistent, high-quality counseling services. Stakeholders described turnover among counselors and the difficulty of recruiting qualified professionals as major barriers to continuity of care. Stigma also continues to affect help-seeking behavior. Trust-building with providers is also essential. Housing instability further compounds behavioral health issues, with organizations like Extended Housing struggling to expand supportive housing for individuals with mental health or substance use disorders due to community resistance and zoning barriers.

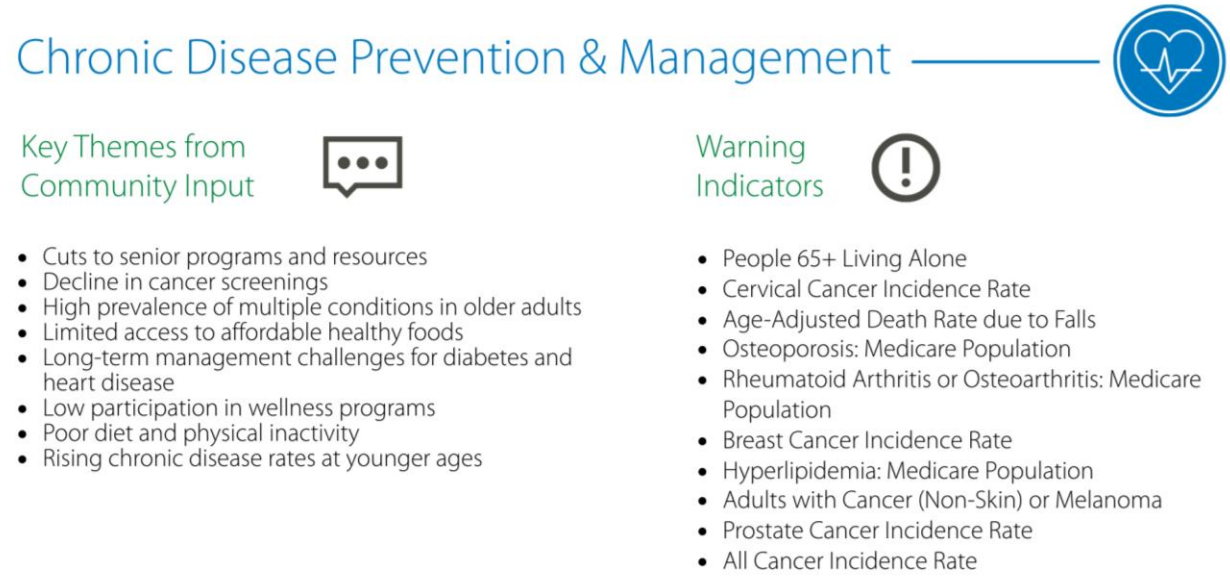
Secondary data illustrates rates of mortality across Lake County regarding behavioral health. Half of all driving deaths in the county (50.0%) involve alcohol, which is one of the highest rates across all U.S. counties, and trending upward. The rate of overdose deaths from opioid and other substance use is also relatively high (39.4 deaths per 100,000). This county rate is within the highest quartile of all U.S. counties although, notably, it is similar to the state-wide Ohio rate (40.4 deaths per 100,000).

Secondary data demonstrate county-wide challenges with psychological well-being. The average number of days residents report poor mental health is within the highest quartile

of U.S. counties and increasing. Lake County also has a death rate due to suicide (16.8 deaths per 100,000) that exceeds both the state-wide rate and the Healthy People 2030 target.

Geographic analysis using Conduent HCI's Mental Health Index (MHI), which assesses mental health risk based on local health-related social need indicators, demonstrates where mental health needs are greatest in the Mentor Hospital community. There are four zip codes in the community with an MHI score exceeding 75, 44095 (Eastlake), 44077 (Painesville), 44057 (Madison), and 44092 (Wickliffe), indicating especially high mental health needs compared to other U.S. zip codes.

Prioritized Health Need #3: Chronic Disease Prevention and Management



Based on the Mentor Hospital stakeholder interviews conducted as part of their 2025 CHNA, several pressing concerns around chronic disease prevention and management were identified by stakeholders. Participants noted that diabetes, hypertension, heart disease, and other long-term conditions remain widespread challenges for residents, with significant variation across groups. Barriers such as limited access to preventive screenings, inconsistent follow-up care, and cost-related challenges in maintaining treatment were cited as persistent drivers of poor outcomes. Stakeholders also emphasized that nutrition, physical inactivity, and lack of health education contribute to the onset and progression of chronic illness in the community.

Interviewees underscored the importance of a holistic approach to prevention and management. This includes improving access to early detection, increasing patient engagement in care plans, and expanding community-based wellness initiatives that address root causes such as food insecurity and lack of exercise opportunities. Older adults were identified as a particularly susceptible population, as many face challenges affording medications, maintaining mobility, and navigating multiple comorbidities.

Stakeholders also noted that culturally tailored outreach and education are needed to build trust and ensure equal participation in chronic disease programs.
Overall, the findings point to the need for coordinated strategies that integrate healthcare, social services, and community partners. Sustained focus on prevention, access, and tailored support for at-risk groups was described as essential to reducing the long-term burden of chronic disease and improving health outcomes across Lake County.

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 the need for more education and accessible programs to encourage healthier lifestyles. Many noted that families struggle to afford nutritious food, contributing to obesity and chronic disease. Access to wellness resources was seen as uneven, with some communities lacking affordable fitness opportunities or nutrition counseling. Community leaders suggested expanding partnerships with schools, food pantries, and local organizations to promote healthy eating and active living.

Based on consumer behavior data, adults in Lake County are less likely to cook meals at home than those in most other Ohio counties. Conduent HCI's Food Insecurity Index (FII) uses widely available community characteristics to estimate food access needs at a granular level. In the Mentor Hospital community, the three zip codes with the greatest food access needs are 44077 (Painesville), 44057 (Madison), and 44092 (Wickliffe), with FII values of 55.5, 53.4, and 50.7, respectively.

Cancer
Cancer was a frequently discussed concern, particularly related to screening and early detection. Stakeholders reported that residents often delay screenings due to cost, transportation barriers, or lack of awareness. Outreach and education were viewed as critical to increasing participation in cancer prevention programs. Participants also highlighted differences in health outcomes, noting that low-income and uninsured residents face greater challenges in accessing timely cancer care.

Across Lake County, the risk of developing any cancer (488.5 per 100,000) exceeds both the state-wide and national rate. Cancers that primarily affect women are especially concerning in the county. Rates of both breast cancer (141.9 per 100,000 females) and cervical cancer (10.6 per 100,000) are in the highest quartile of all U.S. counties, and significantly increasing, despite relatively high rates of cervical cancer screening and mammography.

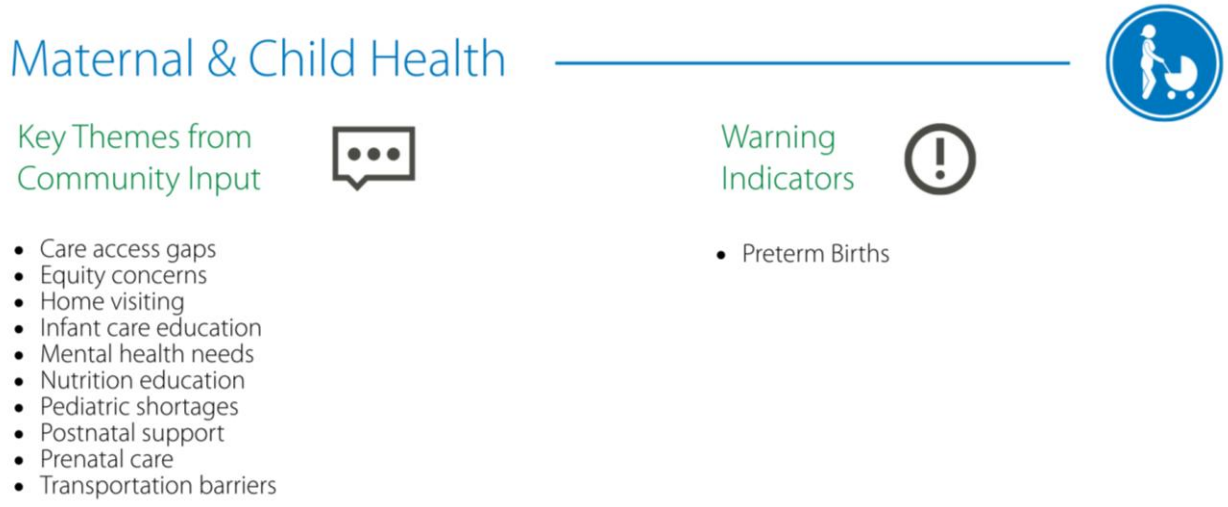
Diabetes, Heart Disease, Stroke, and Other Chronic Conditions
Cardiovascular health was noted as a key issue in the community, with hypertension, high cholesterol, and stroke risk identified as prevalent conditions. Stakeholders pointed to lifestyle factors, including poor diet and lack of physical activity, as major contributors. Limited availability of cardiology and rehabilitation services close to home was cited as a barrier, particularly for rural and older residents. Better integration of preventive care and early intervention programs was suggested.

Medicare data indicate a high prevalence of hyperlipidemia in Lake County, a major risk factor for heart disease. In total, hyperlipidemia affects 70% of Medicare recipients, placing Lake County in the top quartile of all Ohio counties. Medicare recipients are also more likely to experience a stroke in Lake County (6% of Medicare enrollees) than in most other Ohio counties. This risk for stroke is higher among the county's Black/African American population (10% of Medicare enrollees). The county-wide risk of death due to stroke is lower than the state-wide rate, but well above the Healthy People 2030 target, and rising.

Older Adult Health
The aging population in Lake County faces unique barriers to chronic disease management. Interviewees described challenges with affordability of medications, transportation to appointments, and access to supportive housing or long-term care. Older adults often experience multiple chronic conditions simultaneously, intensifying the need for coordinated, comprehensive care. Stakeholders emphasized the importance of preventive screenings, fall prevention programs, and accessible wellness opportunities tailored for seniors.

Across the Mentor Hospital community, the median age is 5.1 years older than that of Ohio, and there is also a larger share of the population aged 65 and above (23.9% vs. 19.9%). Across Lake County, the percentage of older adults living alone is in the top quartile of all U.S. counties, which can have a significant impact on the population's access to consistent, regular health care. One of the other major risks of older adults living alone is the opportunity for unintentional injury. In fact, the death rate due to falls in Lake County is higher than nearly all other Ohio counties.

Prioritized Health Need #4: Maternal and Child Health



Stakeholders emphasized that Maternal and Child Health is a vital area of focus within the community, particularly given concerns about access, affordability, and the availability of specialized services. Conversations highlighted that mothers often face challenges in navigating prenatal care, mental health needs during and after pregnancy,

and consistent pediatric follow-up for their children. Interviewees described barriers such as transportation difficulties, gaps in care coordination, and the need for expanded educational support for parents.

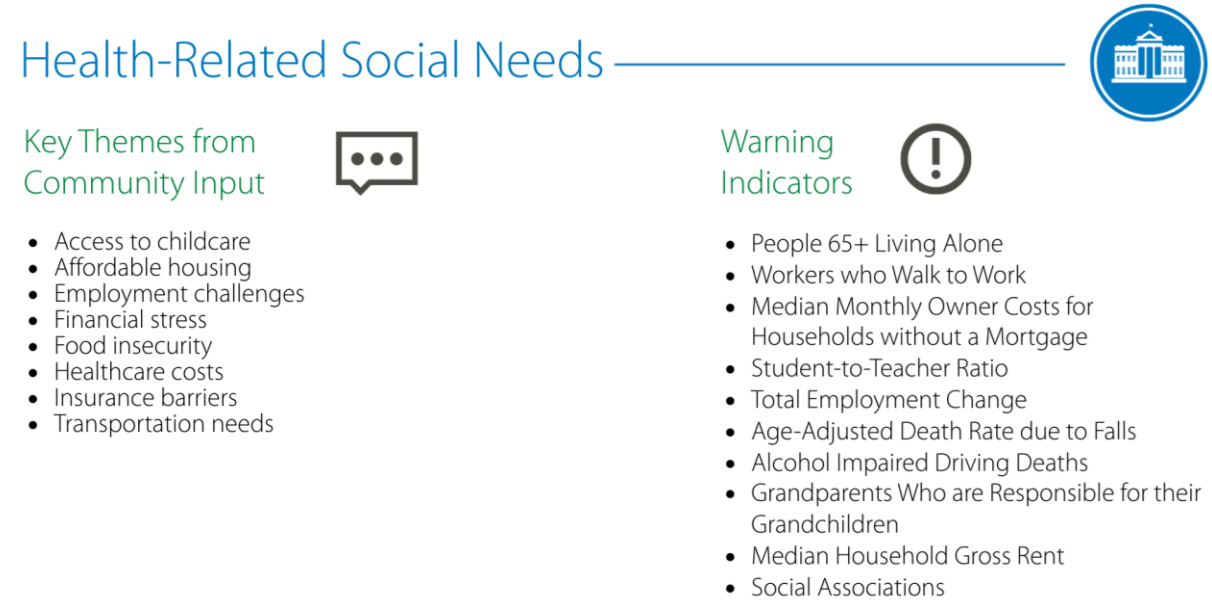
Participants also underscored the importance of addressing social and economic influences that directly impact maternal and child health outcomes. Food insecurity, housing instability, and lack of affordable childcare were repeatedly cited as compounding factors that heighten stress for families and limit their ability to maintain healthy routines. Stakeholders also raised concerns about differences in maternal health outcomes across different groups, underscoring the need for culturally responsive and equal approaches to care.

Finally, stakeholders suggested that stronger partnerships between hospitals, community organizations, and schools could provide greater continuity of support for families. Ideas included offering expanded parenting classes, strengthening outreach programs for prenatal and postnatal support, and providing integrated behavioral health services for both mothers and children. Collectively, the feedback reflects an understanding that maternal and child health outcomes are shaped by clinical care and the broader social and community environment that supports families.

Broadly speaking, secondary data indicated that maternal and child health outcomes in Lake County were similar to or better than surrounding geographies. The rate of preterm births (10.6%) is similar to the state-wide rate (10.8%), and higher than the Healthy People 2030 target. However, the rate of mothers receiving early prenatal care is higher than most other Ohio counties and continues to significantly improve. Rates of newborns with low birthweight are also low, and the prevalence of childcare centers across the county is high.

The overall child mortality rate in Lake County is relatively low, compared to Ohio and U.S. rates. However, this mortality rate is higher for Black/African American children, compared to the county-wide child population (131.0 vs. 39.2 deaths per 100,000). Additional social factors may also impact children's health across Lake County. Children in Lake County are more likely to live in single-parent households than in most other Ohio counties, and the rate of grandparents acting as primary caretakers for their grandchildren is higher than state-wide and national rates.

Prioritized Health Need #5: Health-Related Social Needs



In the Mentor 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 pointed to challenges related to poverty, unemployment, transportation barriers, and housing instability as persistent obstacles to maintaining health and accessing care. Many respondents stressed that these issues create cycles of disadvantage, where limited financial resources force families to make difficult choices between healthcare, food, and housing, further compounding differences in health outcomes.

Participants also noted the influence of social and environmental conditions on chronic disease, maternal and child health, and behavioral health outcomes. Limited access to affordable, healthy food was cited as a contributing factor to obesity and other chronic conditions, while the lack of reliable transportation was described as a barrier to attending appointments or accessing preventive services. Stakeholders also observed that lower-income families and older adults often face the greatest burden of these challenges, with many struggling to navigate existing support systems or access available resources.

In addition, community members pointed to a growing awareness of the need for coordinated support systems that go beyond clinical care. They expressed that addressing health-related social needs requires partnerships between hospitals, social service providers, and local government to create sustainable improvements. Stakeholders emphasized the importance of cross-sector collaboration to expand affordable housing, improve public transportation, and strengthen access to community-based support services, positioning these as essential strategies for addressing the root causes of poor health outcomes in the Mentor community.

The Mentor Hospital community has a median income that's nearly 25% higher than the overall Ohio median income ($84,669 vs. $68,488). Despite this relative affluence, county residents are more likely to spend a large share of their income on rent or homeowner costs than in most other Ohio counties. Likewise, although the Mentor Hospital community has a lower unemployment rate than the state-wide unemployment rate, the rate of job growth in the county is in the lowest quartile of all Ohio counties.

Social connections and isolation are also areas of concern across this community. The percentage of youth not in school or working (2.2%) is higher in Lake County than most other Ohio counties. The overall county population is also less likely to belong to any business, political, civic, religious, or other membership organizations. This rate of social associations is in the lowest quartile of all Ohio counties, and has been significantly trending downward, which may suggest increasing levels of social isolation.

Prioritized Health Needs in Context

Each of the five community health needs explored above reflect persistent and interconnected challenges shaped by broader social, economic, and environmental conditions. Together, these findings underscore the importance of place and needs-based approaches to improve health outcomes. The following sections provide an overview of the demographic and social factors influencing health in the Mentor 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 Mentor 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.

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

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

Geography and Data Sources

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

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

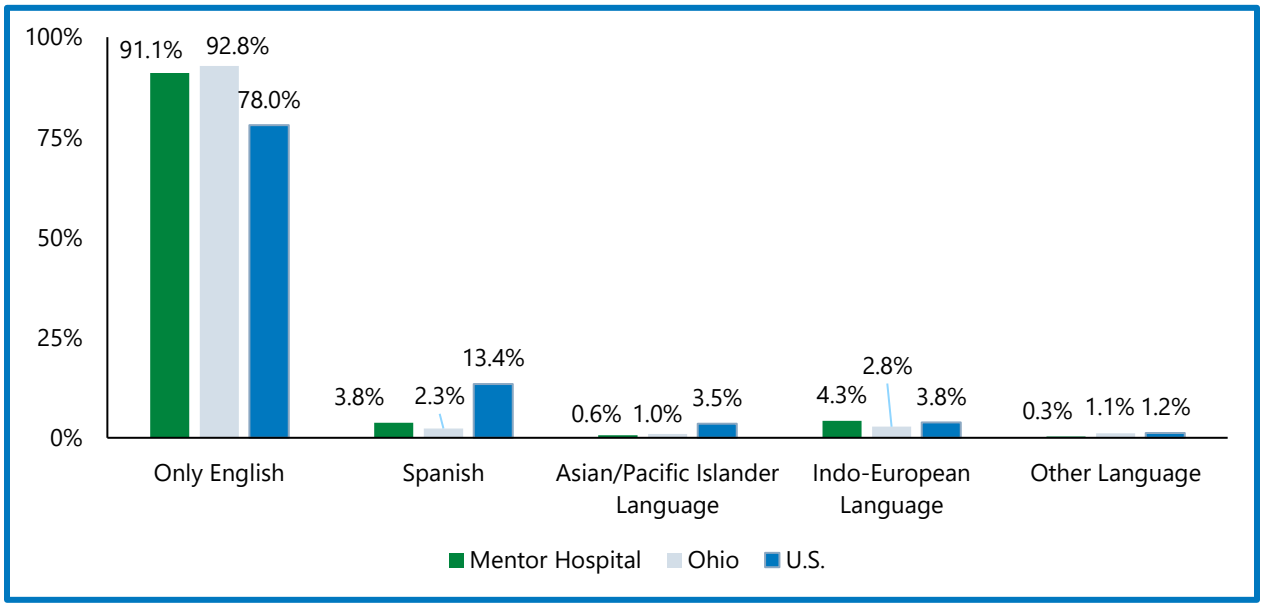
Population Demographics of the Mentor Hospital Community

According to the 2024 Claritas Pop-Facts® population estimates, the Mentor Hospital community has an estimated population of 156,718 persons. The median age in the community is 45.4 years, which is older than that of Ohio (40.3 years). More than a quarter of the population (28.3%) is between 55-74 years old.

In the Mentor Hospital community, the majority of the population is White (83.3%), which is a higher portion than that of the Ohio population (75.7%). Additionally, 5.2% of the population is Black or African American, and 6.8% is Hispanic or Latino of any race.

As shown in Figure 2, the vast majority of the Mentor Hospital community aged five and above speaks English at home (91.1%); 3.8% speak Spanish, and 4.3% speak another Indo-European language. Understanding countries of origin and language spoken at home can help inform the cultural and linguistic context for the health and public health system. Primary language spoken in the home can also be a proxy for acculturation into the community.

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



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

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

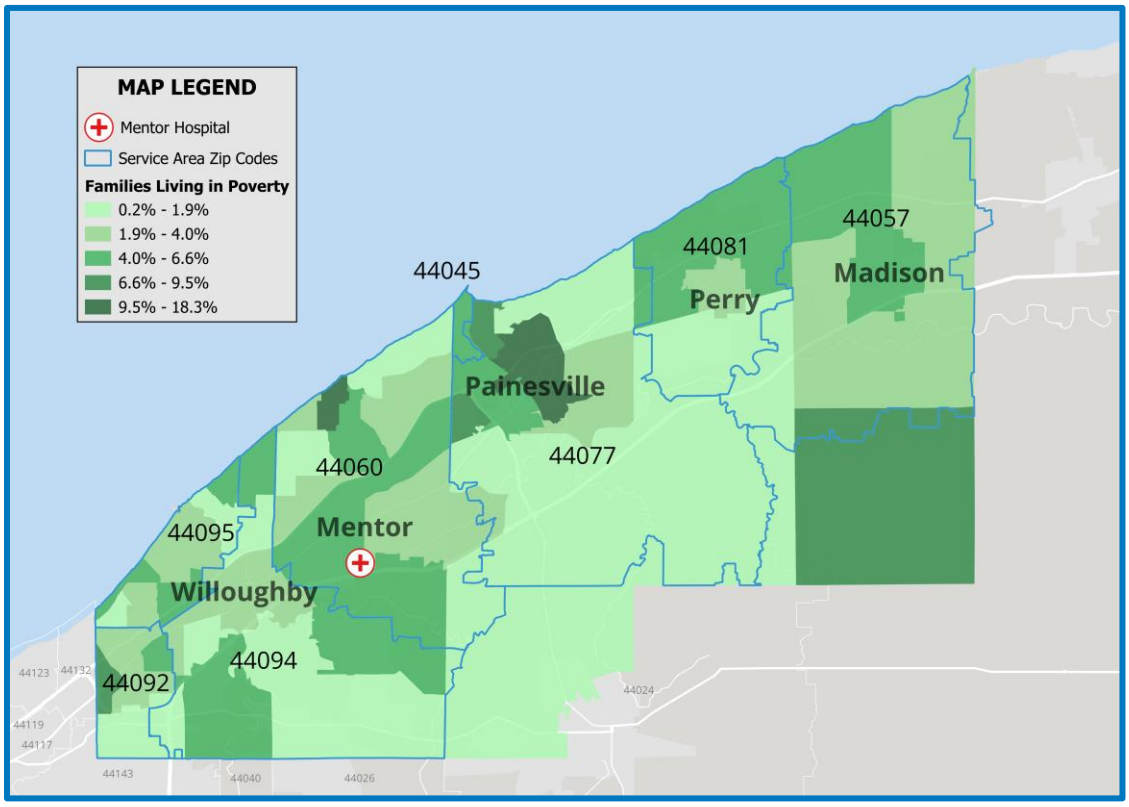
Income and Poverty

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 Mentor Hospital Community is $84,669 which is higher than the surrounding state of Ohio ($68,488).

Federal poverty thresholds are set every year by the Census Bureau and vary by size of family and ages of family members. In the Mentor Hospital Community, 4.1% of families live below the poverty level, which is less than half the state-wide and national values (9.4% and 8.8%, respectively). Poverty levels differ geographically across the Mentor Hospital community (Figure 3), and the zip codes 44077 (Painesville), 44045 (Grand River), and 44057 (Madison) have the highest concentrations of poverty (5.1%, 4.9%, and 4.8%, respectively).

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



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

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

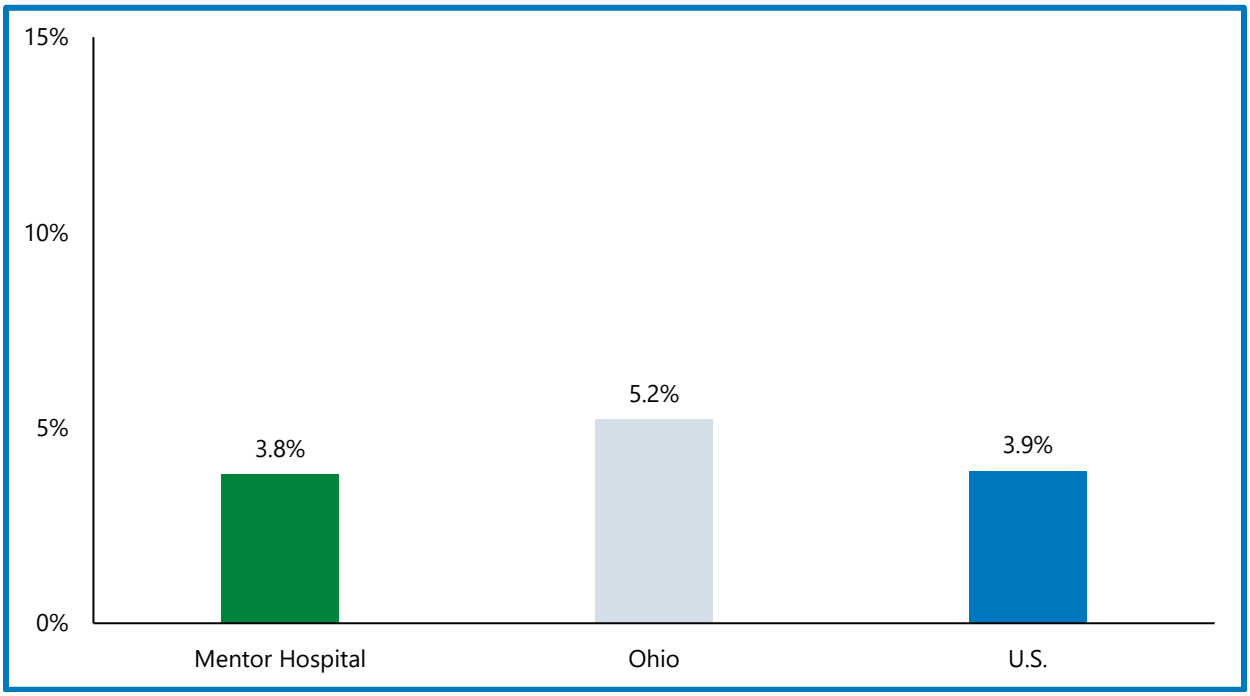
[4] Robert Wood Johnson Foundation. Health, Income, and Poverty. https://www.rwjf.org/en/library/research/2018/10/health--income-and-poverty-where-we-are-and-what-could-help.html

Education and Employment

The Mentor Hospital community population has relatively high levels of educational attainment. The vast majority of the population has a high school degree or higher (94.7%), and a third (33.5%) hold a bachelor's degree or higher. Both of these rates are higher than the state-wide Ohio rates (91.4% and 30.1%, respectively).

The unemployment rate in the Mentor Hospital community is 3.8%, which is similar to the nation-wide unemployment rate (3.9%), but lower than that of Ohio (5.2%).

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



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

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

Education is an important indicator of health and wellbeing. Education can lead to improved health by increasing health knowledge, providing better job opportunities and higher income, and improving social and psychological factors linked to health.[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

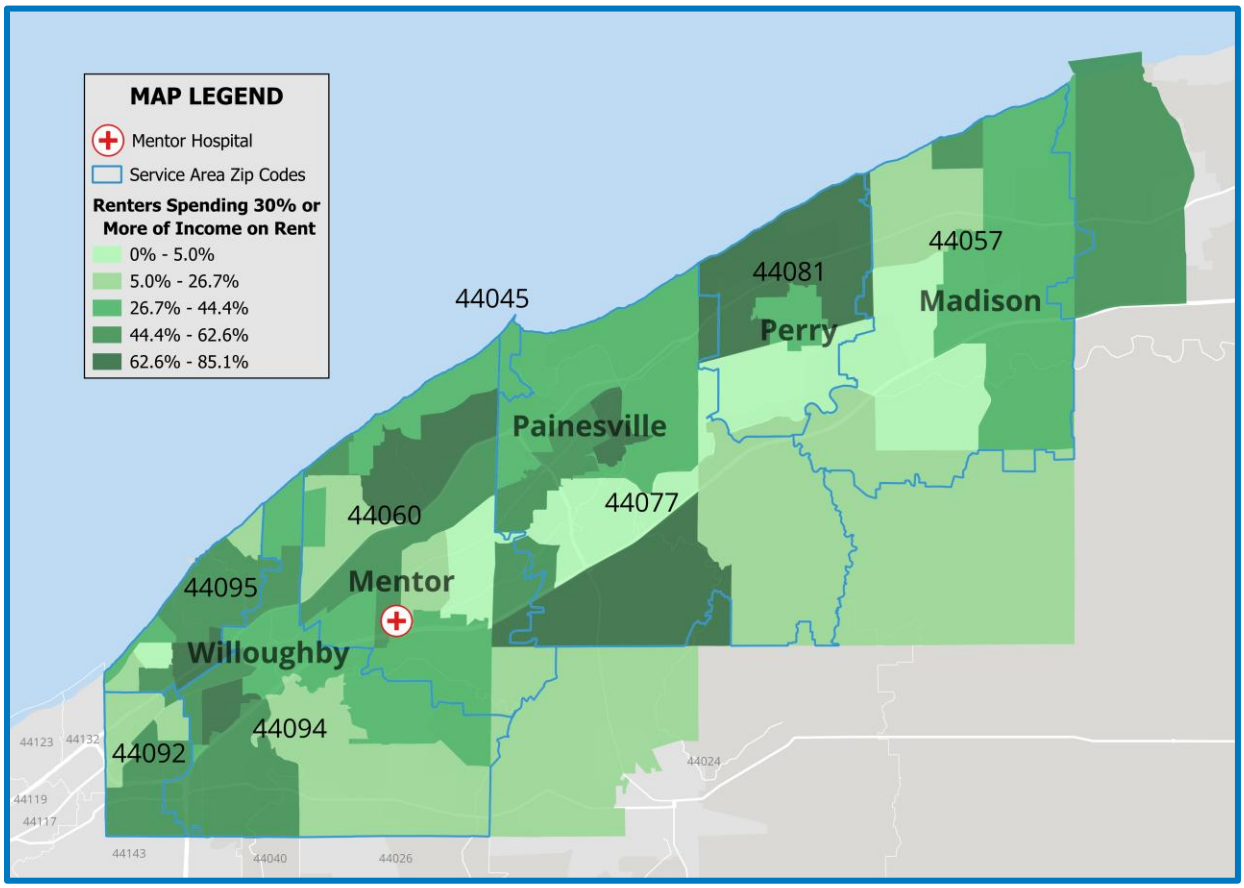
[6] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/social-determinants-health/literature-summaries/employment

Housing and Built Environment

Safe, stable, and affordable housing provides a critical foundation for health and wellbeing. We examined how many renters across the Mentor Hospital community had a high rent burden, costing 30% or more of their household income. We also examined how many households had severe housing problems, including: including: overcrowding, high housing costs, lack of kitchen, or lack of plumbing facilities.

Across Lake County, 42.4% of renters spend at least 30% of their income on rent, and residents are most likely to have burdensome rent costs in zip codes 44081 (Perry) and 44095 (Eastlake). About one in ten households across the county (9.9%) have severe housing problems, which is lower than the state-wide and national averages (12.7% and 16.7%, respectively).

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



Census tract and zip code values: American Community Survey five-year (2019-2023) estimates

Home internet access is an essential home utility for accessing healthcare services, including making appointments with providers, getting test results, and accessing medical records. Many Lake County households have an internet subscription (90.8%). At the zip code level, the lowest levels of internet access in the Mentor Hospital community are in 44057 (Madison) and 44095 (Eastlake), where 89.2% and 89.5% of households have an internet subscription, respectively.

Community Health Indices

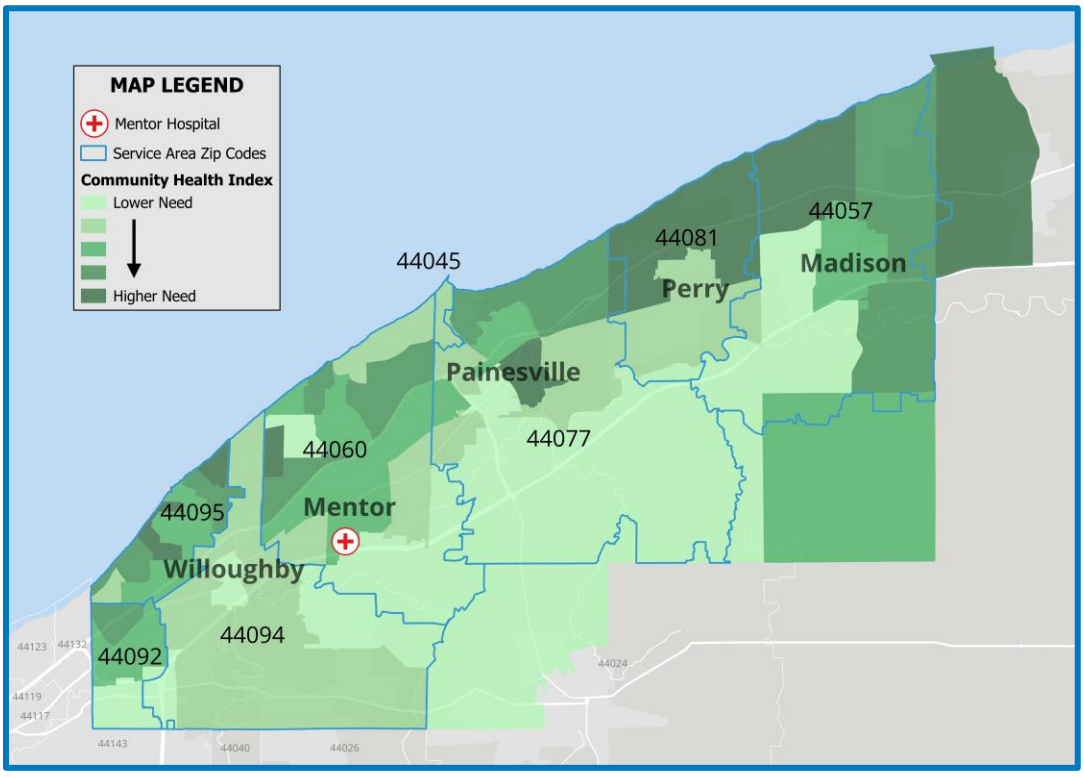
A map index that visualizes social and economic drivers of health at a specific geographic level serves as a critical decision-making tool by highlighting localized differences in health outcomes that may be obscured in broader geographic analyses. The three indices below highlight differences in community health outcomes, mental health outcomes, and food insecurity for the Mentor 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 health-related social needs data that is strongly associated with poor health outcomes, such as preventable hospitalization or premature death, to estimate which geographic areas have the greatest health needs. Each geographic area is given an index value between 0 and 100, based on how it compares to other areas across the country.

Figure 6 illustrates which census tracts experience the greatest relative health needs in the Mentor Hospital community, as indicated by the darkest shade of green. At the zip code level, the greatest areas of need are in the zip codes 44057 (Madison), 44095 (Eastlake), and 44081 (Perry), with index values of 49.3, 40.0, and 39.2, respectively. See Appendix B for additional details about the CHI and a table of CHI values for each zip code in the region.

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

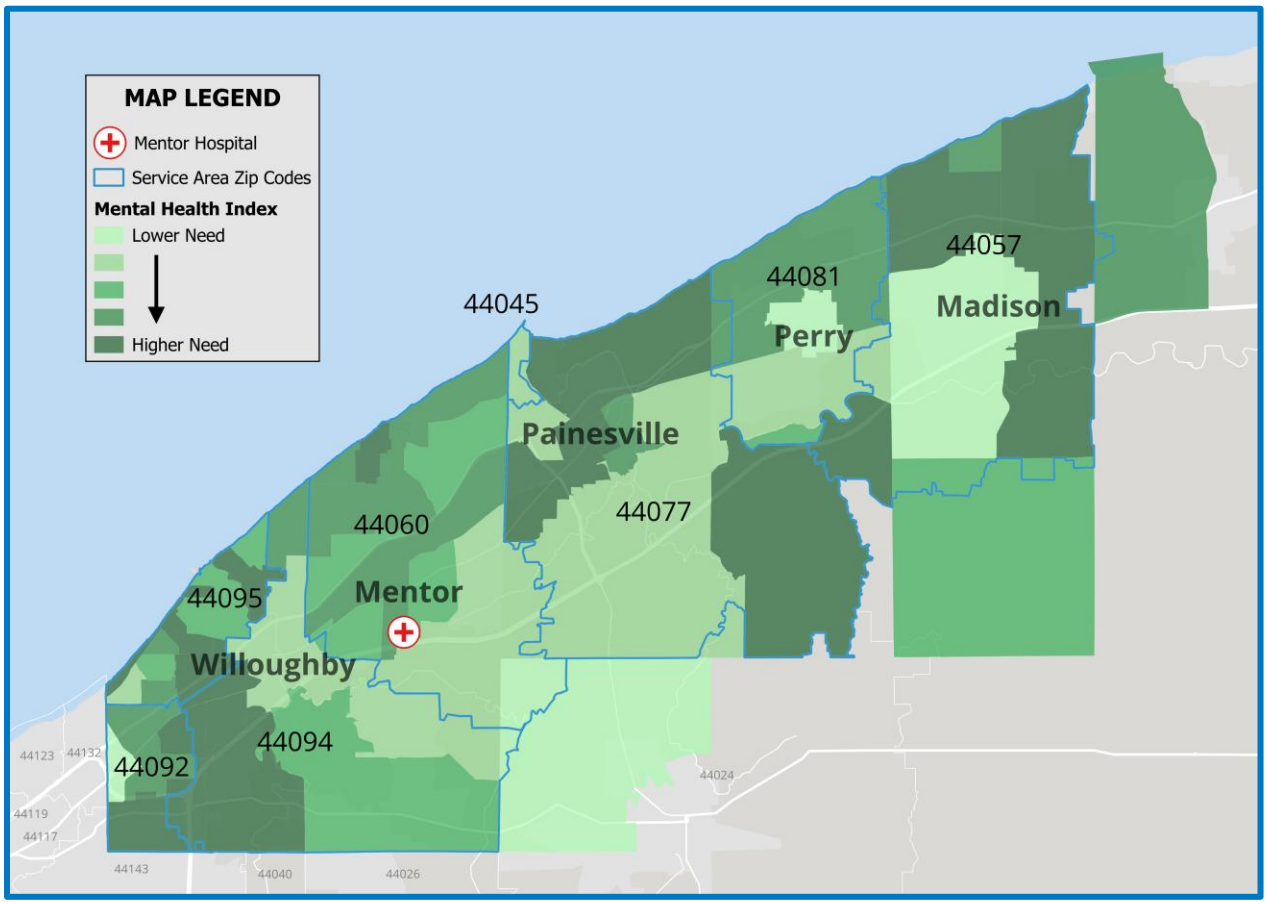


Mental Health Index

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

Figure 7 illustrates which census tracts experience the greatest relative need related to mental health in the Mentor Hospital community, as indicated by the darkest shade of green. Out of the eight zip codes in the region, four had MHI values above 75, indicating especially high mental health needs compared to other U.S. zip codes: 44095 (Eastlake), 44077 (Painesville), 44057 (Madison), and 44092 (Wickliffe). See Appendix B for additional details about the MHI and a table of MHI values for each zip code in the Mentor Hospital community.

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

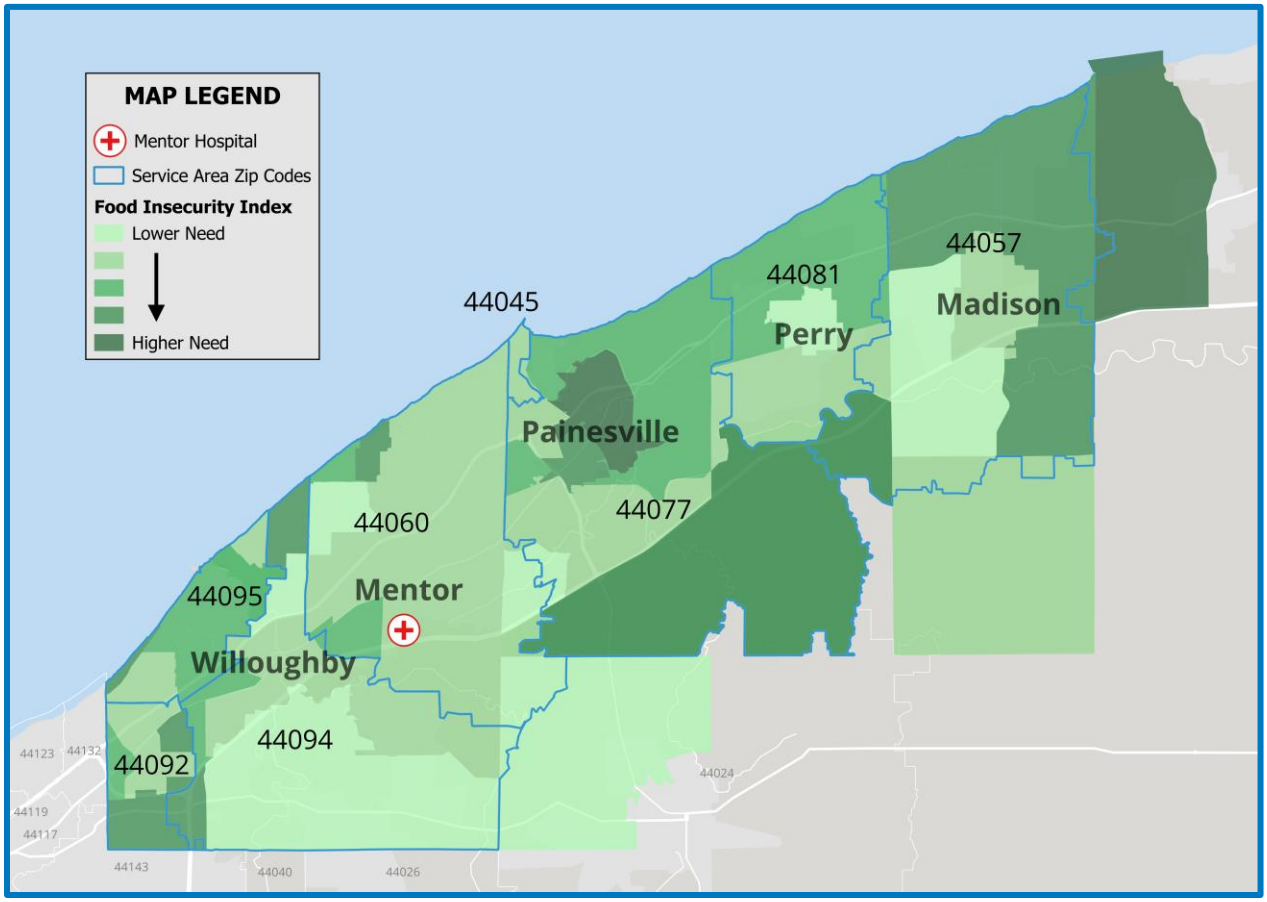


Food Insecurity Index

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

Figure 8 illustrates which census tracts experience the greatest relative need related to food insecurity in the Mentor Hospital Community, as indicated by the darkest shade of green. At the zip code level, the greatest areas of need related to food access are in the zip codes 44077 (Painesville) and 44057 (Madison), with FII values of 55.5 and 53.4, respectively. See Appendix B for additional details about the FII and a table of FII values for each zip code and census tract in the Mentor Hospital community.

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



Other Community Assessment and Improvement Plans

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

2022 Greater Cleveland LGBTQ+ Community Needs Assessment[8]

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

2022 Lake County Community Health Needs Assessment[9]

Priority Health Areas Identified:

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

Primary Data Overview

Community Stakeholder Conversations

Community stakeholders from 13 organizations provided feedback specifically for the Mentor Hospital community. Interviews with each stakeholder varied by individual and the amount of feedback they provided. They 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 Mentor Hospital community:

- City of Mentor
- City of Mentor Police Department
- Cleveland Clinic Children's
- Greater Cleveland Food Bank
- Lake County Health District
- Lake County Council on Aging
- Lake County Board of Developmental Disabilities

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[8] 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

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

- Lake County ADAMHS Board
- Lake County United Way
- Lake County YMCA
- LGBTQ+ Assessment Greater Cleveland / Cleveland Clinic
- Mentor City Schools
- NAMI Geauga County

Stakeholder discussions for the Mentor Hospital 2025 Community Health Needs Assessment affirmed Behavioral Health as a top community priority. Persistent gaps in availability, affordability, and access to care were described as urgent barriers, particularly for youth, older adults, and other populations. Shortages of providers, long wait times, and limited crisis intervention options continue to restrict timely support. Stigma, language barriers, and lack of culturally responsive services further prevent individuals from seeking care. Youth mental health, including depression, anxiety, and trauma, emerged as an area of growing concern, often tied to family stress and the lingering impacts of the COVID-19 pandemic.

Access to Healthcare and Chronic Disease Prevention and Management were also recurring themes across stakeholder conversations. Residents face significant challenges related to transportation, geographic isolation, financial barriers, and service shortages, which limit both preventive and ongoing care. Chronic conditions such as diabetes, heart disease, hypertension, obesity, and stroke remain prevalent and are frequently connected to poor nutrition, physical inactivity, and environmental stressors. Stakeholders emphasized the importance of expanding mobile health services, integrated care models, and telehealth to improve reach, while also strengthening wellness, nutrition, and lifestyle supports that can prevent or mitigate disease progression.

Concerns specific to Older Adults were highlighted related to Chronic Disease Prevention and Management. Participants shared that many seniors face difficulties accessing specialized care, managing multiple chronic conditions, and navigating fragmented support systems. Transportation limitations, fixed incomes, and social isolation further compound health risks. Stakeholders underscored the need for better coordination of senior services, increased access to affordable care, and community-based supports that promote aging in place and reduce preventable hospitalizations.

Finally, health-related social needs were consistently described as underlying drivers of poor health outcomes. Poverty, unemployment, unstable housing, food insecurity, and financial stress shape health across all age groups and neighborhoods. Barriers such as gaps in public funding, reduced neighborhood investment, and limited social support contribute to persistent inequities. Stakeholders emphasized the importance of coordinated cross-sector strategies that address both clinical needs and upstream social and economic drivers. Community-driven, culturally tailored, and sustainable solutions were viewed as essential to creating lasting health improvements for residents.

The following quotes highlight key themes highlighted in community feedback:

Priority Area	Key Quote	Additional Context
Access to Healthcare	“Transportation is a huge barrier. Even if people have insurance, they cannot always get to the doctor.”	Illustrates how transportation challenges limit access to care, especially in geographically isolated or under resourced communities.
Behavioral Health	“It takes months for someone to get in to see a mental health provider, and by then the crisis has often escalated.”	Highlights the critical shortage of mental health providers and long wait times, reinforcing stakeholder concerns about urgent barriers to timely care.
Chronic Disease Prevention and Management	“We see so many people struggling with diabetes and high blood pressure, but they don’t always have the resources or support to manage it.”	Demonstrates the persistent burden of chronic conditions and the lack of adequate management resources, tying to nutrition and lifestyle barriers.
Maternal and Child Health	"Mothers in the community struggle to access consistent prenatal care, and many families face barriers in finding affordable childcare options."	This quote reflects stakeholder concerns about gaps in maternal and child health services, including prenatal care access and support for young families, which directly impact long-term health outcomes.
Health-Related Social Needs	“People are choosing between paying rent, buying food, or filling their prescriptions.”	Captures how poverty and financial insecurity directly affect health outcomes, emphasizing the link between basic needs and medical care adherence.

Prioritization Methodology

Mentor Hospital's 2025 Community Health Needs Assessment (CHNA) represents its first such effort since opening in 2023, establishing a baseline prioritization process to guide future community health improvement efforts. Through a comprehensive review of stakeholder interviews, secondary data, and an environmental scan, the assessment identified five core priorities of access to care, behavioral health, chronic disease, maternal and child health, and the social and economic conditions that influence health. These findings highlight both the hospital's commitment to evidence-based, community-informed decision-making and the need for collaborative strategies to promote equal health outcomes.

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. Mentor Hospital is part of the Cleveland Clinic East Submarket which includes Mentor, Hillcrest, South Pointe, Marymount, and Euclid hospitals.

Community Partners and Resources

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

Federally Qualified Health Centers and Health Departments

Federally Qualified Health Centers (FQHCs)[10] are community-based clinics that provide comprehensive primary care, behavioral health, and dental services in medically under resourced 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 Mentor Hospital community, community health services are further supported by local public health agencies, including the Lake County General Health District. The following FQHC clinics and networks operate in the Mentor Hospital community:

- Signature Health, Inc.
- Crossroads Health

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

Hospitals

In addition to several Cleveland Clinic hospitals in Northeast Ohio, multiple University Hospitals locations are also situated within the Mentor Hospital community.

Other Community Resources

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

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

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

Comments Received on Previous CHNA

Mentor Hospital opened in 2023, therefore no previous CHNAs have been completed to receive community feedback. 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. Mentor 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 and 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

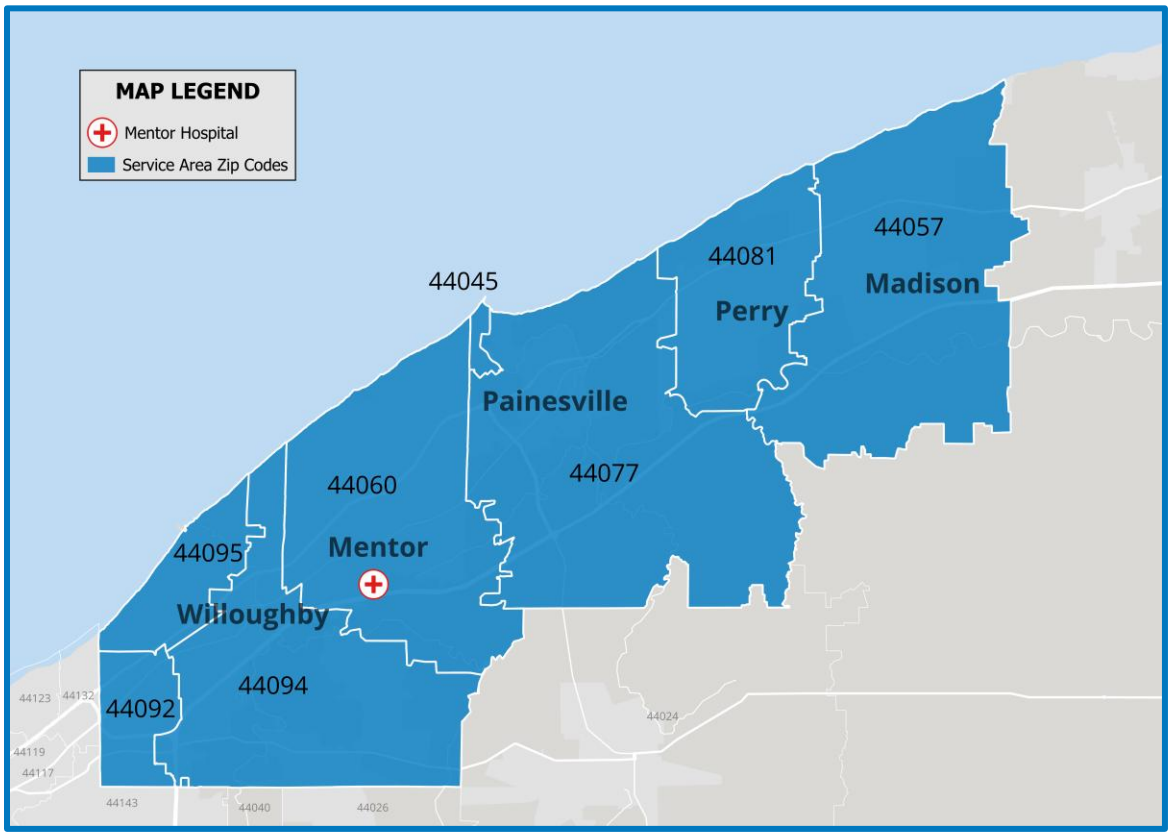
E. Impact Evaluation

F. Acknowledgements

Appendix A: Mentor Hospital Community Definition

The community definition describes the zip codes where approximately 75% of Mentor Hospital Emergency Department discharges originated in 2023. Figure 9 shows the specific geography for the Mentor Hospital community that served as a guide for data collection and analysis for this CHNA. Table 2 lists zip codes and associated neighborhoods that comprise the community definition.

Figure 9: Mentor 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.

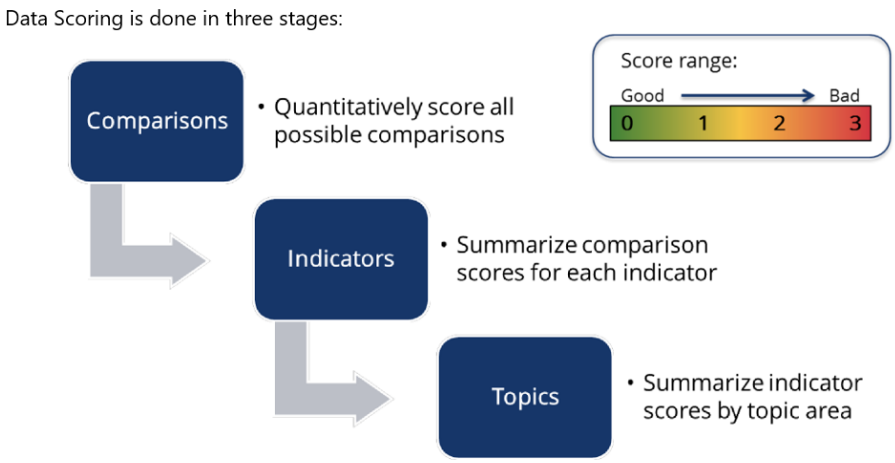
The following is a list of both local and national sources used in the Mentor Hospital Community Health Needs Assessment:

- 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
- Feeding America
- National Cancer Institute
- National Center for Education Statistics
- National Environmental Public Health Tracking Network
- Ohio Department of Education
- Ohio Department of Health, Infectious Diseases
- Ohio Department of Health, Vital Statistics
- Ohio Department of Public Safety, Office of Criminal Justice Services
- Ohio Public Health Information Warehouse
- Ohio Secretary of State
- Purdue Center for Regional Development
- 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 Mentor Hospital Community, this analysis was completed for Lake 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. Three topics were scored at or above this threshold in Lake County (see Table 2). The highest scoring health topic was *Other Chronic Conditions* with a score of 1.72.

Topic Scores

Results from the secondary data topic scoring can be seen in Tables 3 and 4 below. The highest scoring health need in Lake County was *Other Chronic Conditions* with a score of 1.72.

Table 2: Health Topic Scores: Lake County

Health Topic	Score
Other Chronic Conditions	1.72
Alcohol & Drug Use	1.56
Older Adults	1.51
Weight Status	1.46
Heart Disease & Stroke	1.45
Cancer	1.43
Women's Health	1.42
Physical Activity	1.35
Diabetes	1.34
Nutrition & Healthy Eating	1.32
Wellness & Lifestyle	1.30
Mortality Data	1.27
Mental Health & Mental Disorders	1.23
Prevention & Safety	1.23
Respiratory Diseases	1.13
Health Care Access & Quality	1.12
Oral Health	1.11
Immunizations & Infectious Diseases	1.07

Maternal, Fetal & Infant Health	1.07
Tobacco Use	1.01
Sexually Transmitted Infections	0.95
Children's Health	0.79

Table 3: Quality of Life Topic Scores: Lake County

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

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 Mentor Hospital community.

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

Zip Code	CHI Value	FII Value	MHI Value
44045	10.8	5.3	6.6
44057	49.3	53.4	79.2
44060	23.0	21.9	61.5
44077	18.4	55.5	81.2
44081	39.2	21.7	38.6
44092	21.7	50.7	76.3
44094	11.0	32.3	71.3
44095	40.0	36.5	82.6

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 eastern portion of the Mentor Hospital Community.

Figure 12: Census Tract Key (Mentor Hospital, East)

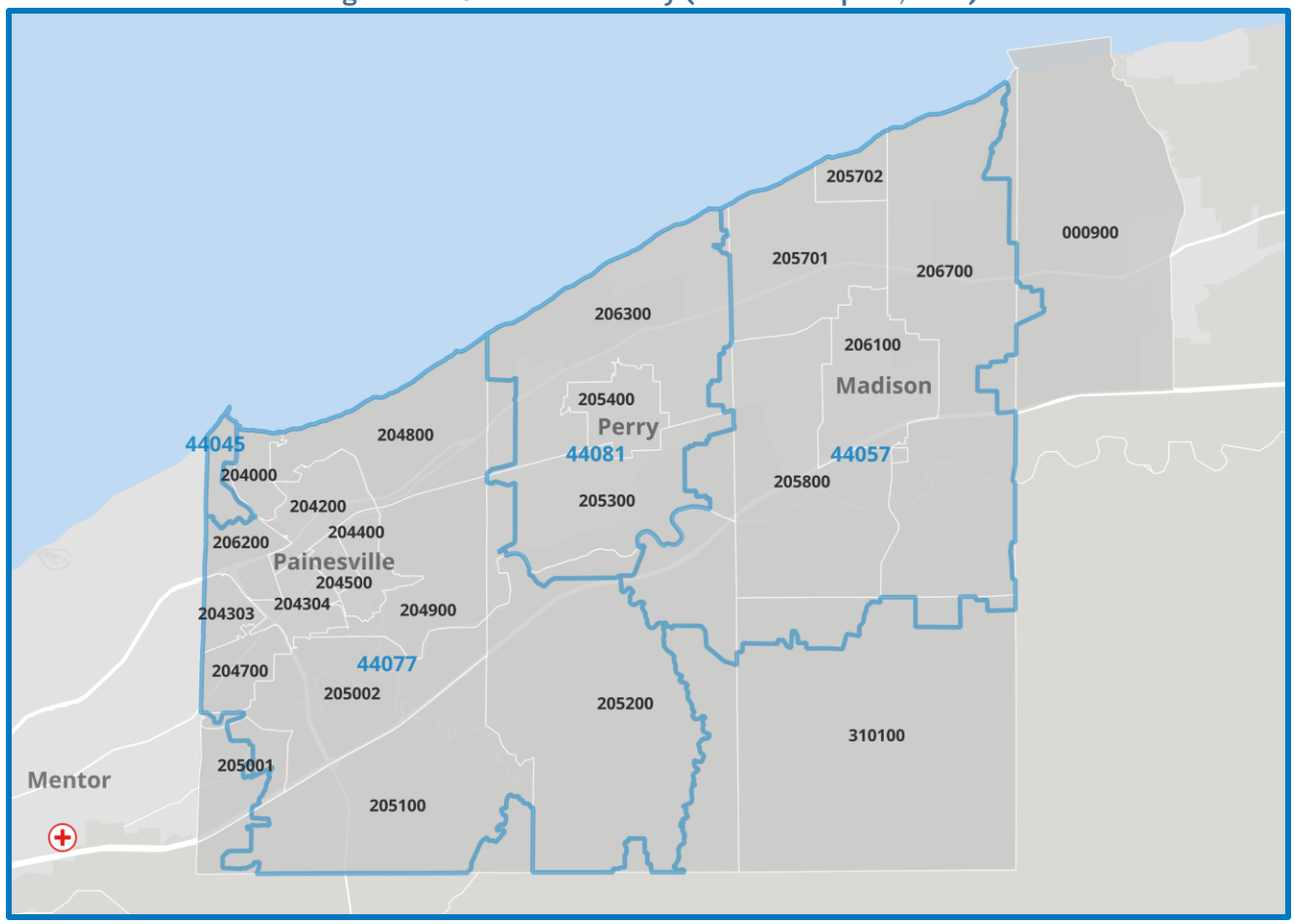


Table 5: Census Tracts by Zip Code (Mentor Hospital, East)

44045	44057	44077	44081
206200	000900	204000	205300
	205701	204200	205400
	205702	204303	206300
	205800	204304	
	206100	204400	
	206700	204500	
	310100	204700	
		204800	
		204900	
		205001	
		205002	
		205100	
		205200	
		206200	

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

Figure 13: Census Tract Key (Mentor Hospital, West)

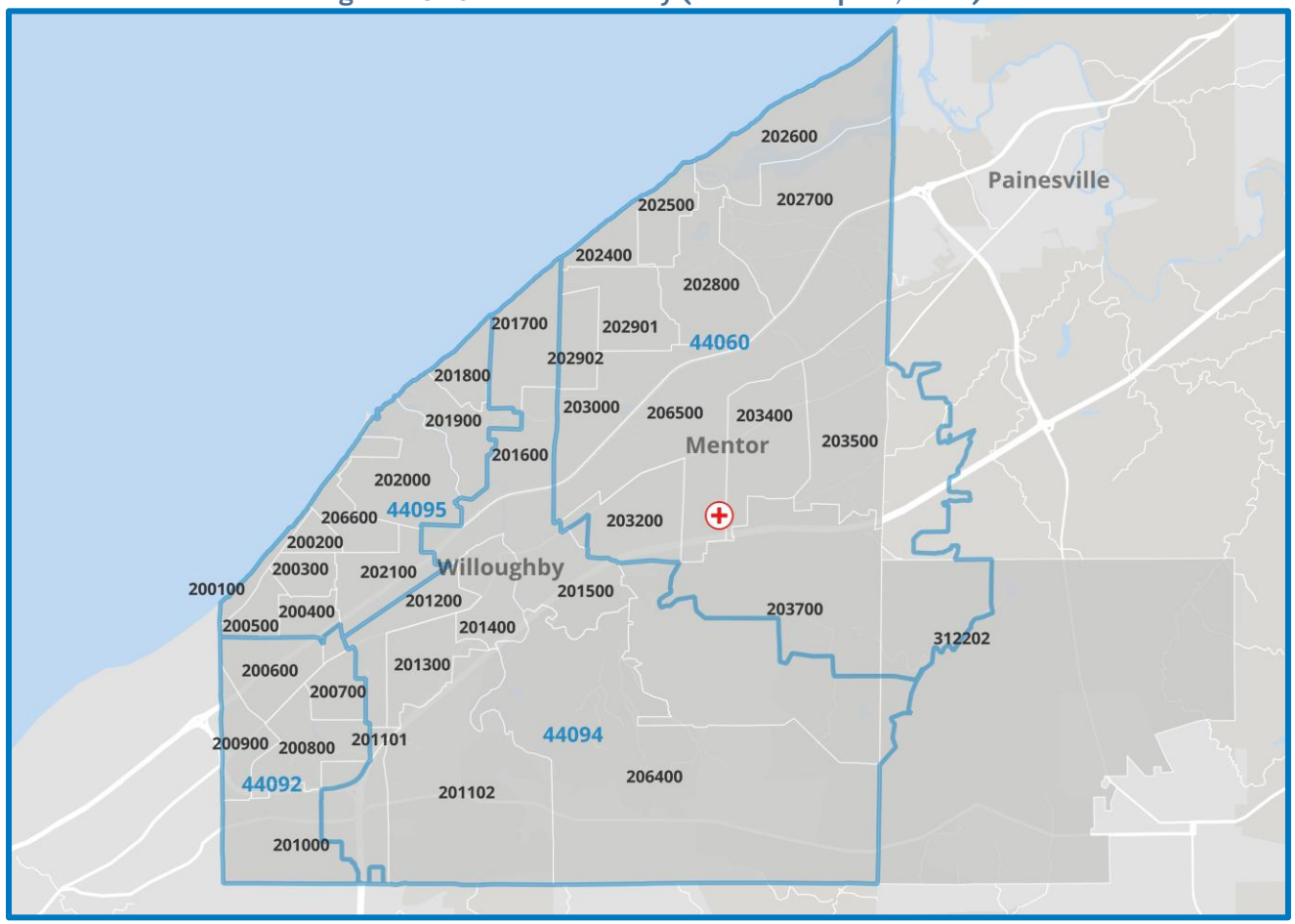


Table 6: Census Tracts by Zip Code (Mentor Hospital, West)

44060	44092	44094	44095
202400	200600	201101	200100
202500	200700	201102	200200
202600	200800	201200	200300
202700	200900	201300	200400
202800	201000	201400	200500
202901		201500	201800
202902		206400	201900
203000			202000
203200			206600
203400			
203500			
203700			
206500			
312202			

Community Health Index (CHI)

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

HOW IS THE INDEX VALUE CALCULATED?

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

WHAT DO THE RANKS AND COLORS MEAN?

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

Food Insecurity Index (FII)

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

HOW IS THE INDEX VALUE CALCULATED?

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

WHAT DO THE RANKS AND COLORS MEAN?

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

Mental Health Index (MHI)

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

HOW IS THE INDEX VALUE CALCULATED?

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

WHAT DO THE RANKS AND COLORS MEAN?

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

Data Considerations

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

Data scores represent the relative community health need according to the secondary data for each topic and should be considered a comprehensive result on their own. In addition, these scores reflect the secondary data results for the population and do not represent the health or health-related social needs 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

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

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

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

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

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

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

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

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

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

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

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

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

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

All Indicator Scores by Topic Area

Below is a complete list of all indicators 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 89 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	Feeding America
12	National Cancer Institute
13	National Center for Education Statistics
14	National Environmental Public Health Tracking Network
15	Ohio Department of Education
16	Ohio Department of Health, Infectious Diseases
17	Ohio Department of Health, Vital Statistics
18	Ohio Department of Public Safety, Office of Criminal Justice Services
19	Ohio Public Health Information Warehouse
20	Ohio Secretary of State
21	Purdue Center for Regional Development
22	U.S. Bureau of Labor Statistics
23	U.S. Census - County Business Patterns
24	U.S. Census Bureau - Small Area Health Insurance Estimates
25	U.S. Environmental Protection Agency
26	United For ALICE

Table 9: All Lake County Secondary Data Indicators

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

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

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

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

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

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

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

0.97	Social Vulnerability Index	*Score*	0.1				*2022*	6
0.97	Solo Drivers with a Long Commute	*percent*	31.3		30.5		*2019-2023*	10
0.88	People 25+ with a Bachelor's Degree or Higher	*percent*	30.5		30.9	35.0	*2019-2023*	2
0.85	Age-Adjusted Death Rate due to Firearms	*deaths/ 100,000 population*	7.7	10.7	13.5	12.0	*2018-2020*	6
0.82	Mean Travel Time to Work	*minutes*	23.3		23.6	26.6	*2019-2023*	2
0.82	Substantiated Child Abuse Rate	*cases/ 1,000 children*	3.8	8.7	6.9		*2021*	4
0.79	Adults With Individual Health Insurance	*percent*	22.0		20.5	20.2	*2024*	8
0.74	Persons with Health Insurance	*percent*	93.8	92.4	92.9		*2022*	24
0.71	Death Rate due to Motor Vehicle Collisions	*deaths/ 100,000 population*	6.9		11.1		*2016-2022*	10
0.71	Households with a Smartphone	*percent*	88.3		87.5	88.2	*2024*	8
0.65	Female Population 16+ in Civilian Labor Force	*percent*	61.3		59.2	58.7	*2019-2023*	2
0.65	Gasoline and Other Fuels Spending-to-Income Ratio	*percent*	3.0		3.3	3.1	*2025*	9
0.65	Households with a Computer	*percent*	87.5		85.2	86.0	*2024*	8
0.59	People Living Below Poverty Level	*percent*	8.2	8.0	13.2	12.4	*2019-2023*	2
0.53	Households with One or More Types of Computing Devices	*percent*	94.6		93.6	94.8	*2019-2023*	2
0.53	Per Capita Income	*dollars*	43197		39455	43289	*2019-2023*	2
0.44	Broadband Quality Score	*BQS Score*	65.9		53.4	50.0	*2022*	21

0.44	Digital Divide Index	*DDI Score*	15.0		40.1	50.0	*2022*	21
0.35	Households with an Internet Subscription	*percent*	91.9		89.0	89.9	*2019-2023*	2
0.35	Median Household Income	*dollars*	77952		69680	78538	*2019-2023*	2
0.35	People 25+ with a High School Diploma or Higher	*percent*	93.9		91.6	89.4	*2019-2023*	2
0.35	Persons with an Internet Subscription	*percent*	94.0		91.3	92.0	*2019-2023*	2
0.35	Population 16+ in Civilian Labor Force	*percent*	62.7		60.1	59.8	*2019-2023*	2
0.29	Children Living Below Poverty Level	*percent*	11.5		18.0	16.3	*2019-2023*	2
0.29	Young Children Living Below Poverty Level	*percent*	9.7		20.0	17.6	*2019-2023*	2

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

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

2.06	Homeowner Spending-to-Income Ratio	*percent*	14.5	14.3	13.5	*2025*	9
2.06	Youth not in School or Working	*percent*	2.2	1.7	1.7	*2019-2023*	2
1.94	Mortgaged Owners Median Monthly Household Costs	*dollars*	1472	1472	1902	*2019-2023*	2
1.94	People 65+ Living Below Poverty Level (Count)	*people*	3438			*2019-2023*	2
1.50	Households that are Asset Limited, Income Constrained, Employed (ALICE)	*percent*	24.7	25.0	29.4	*2023*	26
1.47	Unemployed Workers in Civilian Labor Force	*percent*	4.9	5.4	4.5	*April 2025*	22
1.35	Health Insurance Spending-to-Income Ratio	*percent*	6.5	6.6	5.9	*2025*	9
1.35	Home Renter Spending-to-Income Ratio	*percent*	15.5	16.3	17.0	*2025*	9
1.35	Size of Labor Force	*persons*	124299			*Apr-25*	22
1.26	Children Living Below 200% of Poverty Level	*percent*	35.8	38.3	36.1	*2023*	1
1.24	Households with Cash Public Assistance Income	*percent*	2.1	2.5	2.7	*2019-2023*	2
1.21	Households that are Above the Asset Limited, Income Constrained, Employed (ALICE) Threshold	*percent*	65.5	61.5	58.0	*2023*	26
1.18	Day Care Center and Preschool Spending-to-Income Ratio	*percent*	6.6	7.4	7.1	*2025*	9
1.18	Households with Student Loan Debt	*percent*	8.8	9.1	9.8	*2024*	8
1.09	Gender Pay Gap	*cents on the dollar*	0.8	0.7	0.8	*2023*	1

1.09	Residential Segregation - Black/White	*Score*	53.0		69.6		*2025*	10
1.03	Families Living Below 200% of Poverty Level	*Percent*	19.3		22.8	22.3	*2023*	1
1.03	People 65+ Living Below 200% of Poverty Level	*percent*	23.2		28.4	28.1	*2023*	1
1.03	People Living Below 200% of Poverty Level	*percent*	24.8		29.6	28.2	*2023*	1
1.00	Adult Day Care Spending-to-Income Ratio	*percent*	10.2		11.1	11.9	*2025*	9
1.00	Cigarette Spending-to-Income Ratio	*percent*	2.0		2.1	1.9	*2025*	9
1.00	College Tuition Spending-to-Income Ratio	*percent*	11.2		12.6	11.9	*2025*	9
1.00	Utilities Spending-to-Income Ratio	*percent*	5.7		6.1	5.6	*2025*	9
0.97	Income Inequality		0.4		0.5	0.5	*2019-2023*	2
0.94	Child Food Insecurity Rate	*percent*	16.2		20.1	18.4	*2023*	11
0.94	Food Insecurity Rate	*percent*	13.4		15.3	14.5	*2023*	11
0.88	Mortgaged Owners Spending 30% or More of Household Income on Housing	*percent*	20.1	25.5	21.2	28.5	*2023*	1
0.88	People 65+ Living Below Poverty Level	*percent*	7.2		9.5	10.4	*2019-2023*	2
0.88	Unemployed Veterans	*percent*	2.7		2.8	3.2	*2019-2023*	2
0.85	Households Living Below Poverty Level	*percent*	9.8		13.5	12.7	*2023*	26
0.82	Households with a 401k Plan	*percent*	40.7		38.4	40.8	*2024*	8
0.82	Students Eligible for the Free Lunch Program	*percent*	24.6		23.6	43.6	*2023-2024*	13

0.82	Vocational, Technical, and Other School Tuition Spending-to-Income Ratio	*percent*	1.4		1.6	1.5	*2025*	9
0.79	Adults who Feel Overwhelmed by Financial Burdens	*percent*	31.8		34.0	33.6	*2024*	8
0.76	Adults with Disability Living in Poverty	*percent*	21.2		28.2	24.6	*2019-2023*	2
0.76	Overcrowded Households	*percent*	1.2		1.4	3.4	*2019-2023*	2
0.71	Median Household Income: Householders 65+	*dollars*	54575		51608	57108	*2019-2023*	2
0.65	Female Population 16+ in Civilian Labor Force	*percent*	61.3		59.2	58.7	*2019-2023*	2
0.65	Gasoline and Other Fuels Spending-to-Income Ratio	*percent*	3.0		3.3	3.1	*2025*	9
0.65	Households with a Savings Account	*percent*	74.2		70.9	72.0	*2024*	8
0.59	Families Living Below Poverty Level	*percent*	5.2		9.2	8.7	*2019-2023*	2
0.59	People Living Below Poverty Level	*percent*	8.2	8.0	13.2	12.4	*2019-2023*	2
0.53	Per Capita Income	*dollars*	43197		39455	43289	*2019-2023*	2
0.44	Severe Housing Problems	*percent*	9.5		12.7		*2017-2021*	10
0.35	Median Household Income	*dollars*	77952		69680	78538	*2019-2023*	2
0.35	Population 16+ in Civilian Labor Force	*percent*	62.7		60.1	59.8	*2019-2023*	2
0.29	Children Living Below Poverty Level	*percent*	11.5		18.0	16.3	*2019-2023*	2
0.29	Home Child Care Spending-to-Income Ratio	*percent*	2.7		3.2	3.3	*2025*	9
0.29	Student Loan Spending-to-Income Ratio	*percent*	4.0		4.6	4.5	*2025*	9

0.29	Veterans Living Below Poverty Level	*percent*	3.8		7.4	7.2	*2019-2023*	2
0.29	Young Children Living Below Poverty Level	*percent*	9.7		20.0	17.6	*2019-2023*	2
0.00	Homeowner Vacancy Rate	*percent*	0.4		0.9	1.0	*2019-2023*	2

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

0.82	Vocational, Technical, and Other School Tuition Spending-to-Income Ratio	*percent*	1.4		1.6	1.5	*2025*	9
0.35	People 25+ with a High School Diploma or Higher	*percent*	93.9		91.6	89.4	*2019-2023*	2
0.29	Home Child Care Spending-to-Income Ratio	*percent*	2.7		3.2	3.3	*2025*	9
0.29	Student Loan Spending-to-Income Ratio	*percent*	4.0		4.6	4.5	*2025*	9

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

1.15	Liquor Store Density	*stores/ 100,000 population*	6.5		5.6	10.9	*2022*	23
1.00	Utilities Spending-to-Income Ratio	*percent*	5.7		6.1	5.6	*2025*	9
0.97	Social Vulnerability Index	*Score*	0.1				*2022*	6
0.88	Access to Exercise Opportunities	*percent*	87.8		84.2		*2025*	10
0.82	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	0.6		1.9		*2022*	19
0.76	Overcrowded Households	*percent*	1.2		1.4	3.4	*2019-2023*	2
0.71	Access to Parks	*percent*	70.6		59.6		*2020*	14
0.65	Gasoline and Other Fuels Spending-to-Income Ratio	*percent*	3.0		3.3	3.1	*2025*	9
0.65	Houses Built Prior to 1950	*percent*	14.8		24.9	16.4	*2019-2023*	2
0.56	Air Pollution due to Particulate Matter	*micrograms per cubic meter*	6.2		7.9		*2020*	10
0.44	Broadband Quality Score	*BQS Score*	65.9		53.4	50.0	*2022*	21
0.44	Digital Divide Index	*DDI Score*	15.0		40.1	50.0	*2022*	21
0.44	Severe Housing Problems	*percent*	9.5		12.7		*2017-2021*	10

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

1.32	Non-Physician Primary Care Provider Rate	*providers/ 100,000 population*	93.2		148.7		*2024*	10
1.29	Adults with Health Insurance: 18+	*percent*	76.9		74.7	75.2	*2024*	8
1.12	Dentist Rate	*dentists/ 100,000 population*	67.3		65.2	73.5	*2022*	10
1.06	Adults who have had a Routine Checkup	*percent*	79.1			76.1	*2022*	5
0.97	Adults who go to the Doctor Regularly for Checkups	*percent*	67.8		65.2	65.1	*2024*	8
0.97	Adults With Group Health Insurance	*percent*	39.5		37.4	39.8	*2024*	8
0.94	Adults who Visited a Dentist	*percent*	47.5		44.3	45.3	*2024*	8
0.91	Adults with Health Insurance	*percent*	93.8		91.6	89.0	*2023*	1
0.91	Children with Health Insurance	*percent*	97.8		95.1	94.6	*2023*	1
0.82	Persons without Health Insurance	*percent*	4.1		6.1	7.9	*2023*	1
0.79	Adults With Individual Health Insurance	*percent*	22.0		20.5	20.2	*2024*	8
0.74	Persons with Health Insurance	*percent*	93.8	92.4	92.9		*2022*	24
0.71	Adults without Health Insurance	*percent*	4.7			10.8	*2022*	5
0.62	Mental Health Provider Rate	*providers/ 100,000 population*	316.0		349.4		*2024*	10

SCORE	HEART DISEASE & STROKE	UNITS	LAKE COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.21	Hyperlipidemia: Medicare Population	*percent*	70.0		67.0	66.0	*2023*	7

1.94	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	*deaths/ 100,000 population*	43.9	33.4	46.0		*2020-2022*	19
1.85	Stroke: Medicare Population	*percent*	6.0		5.0	6.0	*2023*	7
1.76	Adults who Experienced Coronary Heart Disease	*percent*	8.7			6.8	*2022*	5
1.68	Ischemic Heart Disease: Medicare Population	*percent*	23.0		22.0	21.0	*2023*	7
1.59	High Blood Pressure Prevalence	*percent*	36.2	41.9		32.7	*2021*	5
1.41	Adults who Experienced a Stroke	*percent*	3.9			3.6	*2022*	5
1.41	Adults who Have Taken Medications for High Blood Pressure	*percent*	80.2			78.2	*2021*	5
1.35	Age-Adjusted Death Rate due to Coronary Heart Disease	*deaths/ 100,000 population*	108.6	71.1	101.6		*2020-2022*	19
1.32	Atrial Fibrillation: Medicare Population	*percent*	15.0		15.0	14.0	*2023*	7
1.32	Heart Failure: Medicare Population	*percent*	12.0		12.0	11.0	*2023*	7
1.24	High Cholesterol Prevalence	*percent*	35.1			35.5	*2021*	5
1.15	Hypertension: Medicare Population	*percent*	67.0		67.0	65.0	*2023*	7
0.88	Cholesterol Test History	*percent*	86.9			86.4	*2021*	5
0.71	Age-Adjusted Death Rate due to Heart Attack	*deaths/ 100,000 population 35+ years*	43.9		60.9		*2021*	14

SCORE	IMMUNIZATIONS & INFECTIOUS DISEASES	UNITS	LAKE COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.74	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	10.6		7.8	7.5	*2017-2021*	12

1.50	Syphilis Incidence Rate	*cases/ 100,000 population*	6.9		16.4	15.8	*2023*	16
1.47	Salmonella Infection Incidence Rate	*cases/ 100,000 population*	13.4	11.5	13.8		*2023*	16
1.00	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	10.9		12.3		*2020-2022*	19
0.97	Pneumonia Vaccinations: Medicare Population	*percent*	9.0		9.0	9.0	*2023*	7
0.91	Gonorrhea Incidence Rate	*cases/ 100,000 population*	55.2		168.8	179.5	*2023*	16
0.79	Adults who Agree Vaccine Benefits Outweigh Possible Risks	*Percent*	62.8		59.8	60.4	*2024*	8
0.76	Overcrowded Households	*percent*	1.2		1.4	3.4	*2019-2023*	2
0.62	Flu Vaccinations: Medicare Population	*percent*	51.0		50.0	3.0	*2023*	7
0.56	Tuberculosis Incidence Rate	*cases/ 100,000 population*	0.0	1.4	1.6	2.9	*2023*	16
0.44	Chlamydia Incidence Rate	*cases/ 100,000 population*	204.4		464.2	492.2	*2023*	16

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

0.56	Teen Birth Rate: 15-17	*live births/ 1,000 females aged 15-17*	1.2		6.1	5.6	*2022*	17

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

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

1.41	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	*Percent*	37.6		38.1	38.2	*2024*	8
1.21	Food Environment Index		7.9		7.0		*2025*	10
0.79	Adults who Drank Soft Drinks: Past 7 Days	*percent*	45.7		48.6	47.5	*2024*	8

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

1.32	Depression: Medicare Population	*percent*	17.0	18.0	17.0	*2023*	7
1.32	Heart Failure: Medicare Population	*percent*	12.0	12.0	11.0	*2023*	7
1.15	COPD: Medicare Population	*percent*	12.0	13.0	11.0	*2023*	7
1.15	Hypertension: Medicare Population	*percent*	67.0	67.0	65.0	*2023*	7
1.12	Age-Adjusted Death Rate due to Alzheimer's Disease	*deaths/ 100,000 population*	26.4	33.8		*2020-2022*	19
1.06	Adults 65+ with Total Tooth Loss	*percent*	12.2		12.2	*2022*	5
1.00	Adult Day Care Spending-to-Income Ratio	*percent*	10.2	11.1	11.9	*2025*	9
0.97	Diabetes: Medicare Population	*percent*	24.0	25.0	24.0	*2023*	7
0.97	Mammography Screening: Medicare Population	*percent*	51.0	51.0	39.0	*2023*	7
0.88	People 65+ Living Below Poverty Level	*percent*	7.2	9.5	10.4	*2019-2023*	2
0.79	Chronic Kidney Disease: Medicare Population	*percent*	17.0	19.0	18.0	*2023*	7
0.71	Median Household Income: Householders 65+	*dollars*	54575	51608	57108	*2019-2023*	2
0.62	Alzheimer's Disease or Dementia: Medicare Population	*percent*	5.0	6.0	6.0	*2023*	7

SCORE	ORAL HEALTH	UNITS	LAKE COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
1.32	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	12.3		12.8	12.0	*2017-2021*	12
1.12	Dentist Rate	*dentists/ 100,000 population*	67.3		65.2	73.5	*2022*	10

1.06	Adults 65+ with Total Tooth Loss	*percent*	12.2			12.2	*2022*	5
0.94	Adults who Visited a Dentist	*percent*	47.5		44.3	45.3	*2024*	8

SCORE	OTHER CHRONIC CONDITIONS	UNITS	LAKE COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.38	Osteoporosis: Medicare Population	*percent*	13.0		11.0	12.0	*2023*	7
2.38	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	40.0		39.0	36.0	*2023*	7
1.94	Adults with Arthritis	*percent*	33.4			26.6	*2022*	5
1.12	Age-Adjusted Death Rate due to Kidney Disease	*deaths/ 100,000 population*	11.0		15.1		*2020-2022*	19
0.79	Chronic Kidney Disease: Medicare Population	*percent*	17.0		19.0	18.0	*2023*	7

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

SCORE	PREVENTION & SAFETY	UNITS	LAKE COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.47	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	21.1		12.1		*2020-2022*	19

1.76	Death Rate due to Injuries	*deaths/ 100,000 population*	102.2		100.7		*2018-2022*	10
1.24	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	38.2	20.7	44.7		*2020-2022*	10
1.15	Age-Adjusted Death Rate due to Unintentional Poisonings	*deaths/ 100,000 population*	40.1		46.5		*2020-2022*	19
0.85	Age-Adjusted Death Rate due to Firearms	*deaths/ 100,000 population*	7.7	10.7	13.5	12.0	*2018-2020*	6
0.71	Death Rate due to Motor Vehicle Collisions	*deaths/ 100,000 population*	6.9		11.1		*2016-2022*	10
0.44	Severe Housing Problems	*percent*	9.5		12.7		*2017-2021*	10

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

0.53	Age-Adjusted Death Rate due to Chronic Lower Respiratory Diseases	*deaths/ 100,000 population*	32.2		42.8		*2020-2022*	19
0.44	Adults Who Used Electronic Cigarettes: Past 30 Days	*percent*	6.1		6.9	6.8	*2024*	8
0.29	Adults Who Used Smokeless Tobacco: Past 30 Days	*percent*	1.3		1.7	1.6	*2024*	8

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

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

SCORE	WEIGHT STATUS	UNITS	LAKE COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source

1.59	Obesity: Medicare Population	*percent*	24.0		25.0	20.0	*2023*	7
1.47	Adults 20+ Who Are Obese	*percent*	31.5	36.0			*2021*	6
1.32	Adults Happy with Weight	*Percent*	42.4		42.1	42.6	*2024*	8

SCORE	WELLNESS & LIFESTYLE	UNITS	LAKE COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
1.85	Adults who Frequently Cook Meals at Home	*Percent*	67.7		67.6	67.7	*2024*	8
1.76	Insufficient Sleep	*percent*	38.9	26.7		36.0	*2022*	5
1.59	High Blood Pressure Prevalence	*percent*	36.2	41.9		32.7	*2021*	5
1.59	Poor Physical Health: 14+ Days	*percent*	14.1			12.7	*2022*	5
1.41	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	*Percent*	37.6		38.1	38.2	*2024*	8
1.32	Adults Happy with Weight	*Percent*	42.4		42.1	42.6	*2024*	8
1.24	Self-Reported General Health Assessment: Poor or Fair	*percent*	18.1			17.9	*2022*	5
1.21	Poor Physical Health: Average Number of Days	*days*	4.1		4.3		*2022*	10
1.06	Life Expectancy	*years*	77.0		75.2		*2020-2022*	10
0.94	Self-Reported General Health Assessment: Good or Better	*percent*	86.5		85.4	86.0	*2024*	8
0.79	Adults who Agree Vaccine Benefits Outweigh Possible Risks	*Percent*	62.8		59.8	60.4	*2024*	8
0.79	Adults who Feel Life is Slipping Out of Control	*Percent*	22.7		24.1	23.9	*2024*	8

SCORE	WOMEN'S HEALTH	UNITS	LAKE COUNTY	HP2030	OH	U.S.	MEASUREMENT PERIOD	Source
2.74	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	10.6		7.8	7.5	*2017-2021*	12
2.35	Breast Cancer Incidence Rate	*cases/ 100,000 females*	141.9		132.3	129.8	*2017-2021*	12
0.97	Mammography Screening: Medicare Population	*percent*	51.0		51.0	39.0	*2023*	7
0.88	Cervical Cancer Screening: 21-65	*Percent*	82.8			82.8	*2020*	5
0.88	Mammogram in Past 2 Years: 50-74	*percent*	78.2	80.3		76.5	*2022*	5
0.71	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	18.2	15.3	20.2	19.3	*2018-2022*	12

Additional Demographic Data

The following tables detail the demographic, social, and economic characteristics of the Mentor 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
44045	410
44057	19,354
44060	59,837
44077	58,771
44081	6,864
44092	16,709
44094	37,700
44095	32,163
Mentor Hospital Community (Total)	156,718

Table 11: Age Profile of Hospital Community and Surrounding Geographies

Age Category	Mentor Hospital Community	Ohio
0-4	4.7%	5.6%
5-9	4.9%	5.7%
10-14	5.4%	6.1%
15-17	3.5%	3.8%
18-20	3.7%	4.4%
21-24	4.7%	5.3%
25-34	11.2%	12.4%
35-44	11.6%	12.2%
45-54	11.7%	11.7%
55-64	14.7%	13.0%
65-74	13.6%	11.6%
75-84	7.6%	6.1%
85+	2.7%	2.2%
Median Age	45.4 years	40.5 years

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

	Mentor Hospital Community	Ohio	U.S.
White	83.3%	75.7%	63.4%
Black/African American	5.2%	12.8%	12.4%
American Indian/Alaskan Native	0.3%	0.3%	0.9%
Asian	1.6%	2.7%	5.8%
Native Hawaiian/Pacific Islander	0.0%	0.1%	0.2%
Another Race	3.5%	2.1%	6.6%
Two or More Races	6.2%	6.4%	10.7%
Hispanic or Latino (any race)	6.8%	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

	Mentor Hospital Community	Ohio	U.S.
Only English	91.1%	92.8%	78.0%
Spanish	3.8%	2.3%	13.4%
Asian/Pacific Islander Language	0.6%	1.0%	3.5%
Indo-European Language	4.3%	2.8%	3.8%
Other Language	0.3%	1.1%	1.2%

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

Table 14: Household Income of Hospital Community and Surrounding Geographies

Income Category	Mentor Hospital Community	Ohio
Under $15,000	5.3%	9.5%
$15,000 - $24,999	5.4%	7.8%
$25,000 - $34,999	6.3%	8.0%
$35,000 - $49,999	11.4%	12.2%
$50,000 - $74,999	16.0%	17.0%
$75,000 - $99,999	14.2%	13.0%
$100,000 - $124,999	11.8%	9.9%
$125,000 - $149,999	9.0%	7.0%
$150,000 - $199,999	9.7%	7.2%
$200,000 - $249,999	5.1%	3.5%
$250,000 - $499,999	4.2%	3.4%
$500,000+	1.5%	1.6%
Median Household Income	$84,669	$68,488

Table 15: Poverty Rates in Hospital Community and Surrounding Geographies

	Families Below Poverty
Mentor Hospital Community	4.1%
Ohio	9.4%
U.S.	8.8%
Mentor Hospital Zip Codes	-
44045	4.9%
44057	4.8%
44060	3.8%
44077	5.1%
44081	3.6%
44092	4.1%
44094	3.2%
44095	3.3%

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

Table 16: Educational Attainment of Hospital Community and Surrounding Geographies

	Mentor Hospital Community	Ohio	U.S.
Less than High School Graduate	5.3%	8.6%	10.6%
High School Graduate	29.7%	32.8%	26.2%
Some College, No Degree	21.3%	19.6%	19.4%
Associate Degree	10.2%	8.9%	8.8%
Bachelor's Degree	21.3%	18.6%	21.3%
Master's, Doctorate, or Professional Degree	12.3%	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
Lake County	46.0%
Ohio	45.1%
U.S.	50.4%
Mentor Hospital Zip Codes	-
44045	33.3%
44057	38.0%
44060	39.1%
44077	48.7%
44081	65.8%
44092	41.7%
44094	48.5%
44095	51.4%

All values: American Community Survey (2019-2023)

Table 18: Internet Access in Hospital Community and Surrounding Geographies

	Households with Internet
Lake County	91.9%
Ohio	89.0%
U.S.	89.9%
Mentor Hospital Zip Codes	-
44045	96.6%
44057	86.4%
44060	92.7%
44077	91.1%
44081	89.2%
44092	89.6%
44094	91.9%
44095	88.8%

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 Lake 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 latest Ohio State Health Assessment and Lake County Community Health Assessment (CHA) corroborated the relevance of the five prioritized needs in this 2025 CHNA process for Mentor Hospital.

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

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

- 2023 Ohio State Health Assessment[11]
- 2022 Greater Cleveland LGBTQ+ Community Needs Assessment[12]
- 2022 Lake County Community Health Needs Assessment[13]

[11] Ohio Department of Health. (2023). *Ohio State Health Assessment 2023*. Ohio University; Ohio Department of Health. Retrieved from Ohio Department of Health website.
[12] 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
[13] Lake County General Health District. (2022). *2022 Lake County, Ohio Community Health Needs Assessment*. Lake County General Health District. https://www.lcghd.org/wp-content/uploads/2022/10/FINAL-2022-Lake-County-Ohio-CHNA-Report_09_30_22.pdf

Appendix D: Community Input Assessment Tools and Key Findings

Community Stakeholder Facilitation Guide

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

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

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

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

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

Section #1: Introduction

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

Section #2: Community Health Questions and Probes

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

- **What are the top health-related issues that residents are facing in your community that you would change or improve?**
    - What makes them the most important health issues?
    - What do you think is the cause of these problems in your community?

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

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

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

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

- **How can we make sure that community voices are heard when decisions are made that affect their community?**
    - What would be the best way to communicate with community members about 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 13 organizations provided feedback specifically for the Mentor Hospital community. Interviews with each stakeholder varied by individual and the amount of feedback they provided. They 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 Mentor Hospital community:

- City of Mentor
- City of Mentor Police Department
- Cleveland Clinic Children's
- Greater Cleveland Food Bank
- Lake County Health District
- Lake County Council on Aging
- Lake County Board of Developmental Disabilities
- Lake County ADAMHS Board
- Lake County United Way
- Lake County YMCA
- LGBTQ+ Assessment Greater Cleveland / Cleveland Clinic
- Mentor City Schools
- NAMI Geauga County

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

Access to Healthcare

Access to healthcare was identified as a pressing challenge for the Mentor Hospital community for the 2025 CHNA. Community feedback emphasized that access to healthcare is a significant challenge for many residents, particularly those who rely on Medicaid or have complex medical or behavioral health needs. Participants described persistent difficulties in securing appointments with specialists, such as neurologists and psychiatrists, due to a limited number of providers accepting Medicaid. This shortage often forces residents to travel outside Lake County for care, creating additional financial and logistical barriers. Transportation was also identified as a substantial obstacle, especially for families and individuals with limited mobility or who depend on paratransit services with restricted schedules.

Stakeholders noted that cost and coverage gaps continue to restrict access to necessary services. Families with low incomes, particularly those living in pockets of poverty within the community, often struggle to afford care despite insurance coverage. Interviewees highlighted the growing number of students qualifying for free and reduced lunch as an indicator of broader economic hardship that directly affects health access. Concerns were also raised about grandparents increasingly serving as primary caregivers, which

places additional strain on older adults already managing their own health needs while navigating insurance and caring for younger dependents.

Despite these challenges, the community has shown resilience and collaboration in addressing needs. Local schools, United Way, and organizations such as the Salvation Army have partnered to expand food access and provide essential resources, recognizing the link between nutrition and health outcomes. However, these efforts were consistently described as insufficient compared to the scale of demand, with food distributions often depleted within hours. The shortage of nursing staff and healthcare workers further compounds access issues. Overall, the interviews underscored that improving transportation, expanding Medicaid-accepting providers, and supporting populations such as low-income families and multi-generational households are critical priorities for advancing equal access to healthcare in Mentor.

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

- Cost and Coverage Barriers: Many residents struggle with being uninsured or underinsured. Out-of-pocket costs are high, and for some families even with insurance, deductibles and copays are unaffordable. This creates a “working poor” gap where individuals earn too much to qualify for assistance but cannot realistically afford care.
- Transportation Challenges: Lack of reliable transportation limits access to care, especially for older adults and families in rural areas of Lake County. This barrier contributes to missed appointments and delayed treatment.
- Provider Availability and Wait Times: Participants cited concerns about long wait times for specialty care and mental health services. Recruiting and retaining enough providers, particularly those serving Medicaid or uninsured patients, was seen as a challenge.
- Awareness of Resources: Although Lake County has a strong nonprofit and social service network, community members often do not know how to connect with available resources. Better coordination and integration with systems like 211 and electronic health records were suggested.
- Older Adult Needs: The aging population in the county faces unique barriers, including affordability of prescriptions, access to age-appropriate preventive care, and availability of supportive housing.
- Economic Stressors Affecting Care: Housing costs, food insecurity, and financial instability were frequently mentioned as pressures that make it harder for residents to prioritize healthcare.

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

Cost Barriers & Insurance Gaps

"Part of our funding here goes to our free clinic, and Lake County has one of the last free clinics in the state. The federally qualified health care centers are fantastic, but they want the people that are uninsured. They bring them in and try to see if they're Medicaid qualified—and they're not. This group of underinsured folks is where the next big bubble's going to be."

"I mean, I have OK health insurance, but my out-of-pocket ceiling is $7,000. That's a lot. For other families, that would bury them. And we are painfully unaware of how many people really are living paycheck to paycheck."

Transportation Challenges

"You have all of those other questions they ask about—do you feel safe at home, do you have transportation, etc.—and providers are often seeing people in a more intimate way that they might recognize needs that others may not."

Provider Shortages & Long Wait Times

"Our social services haven't kept pace with the community's needs. We knew our community was aging, but resources didn't expand accordingly. Older adults are disproportionately suffering."

"The group that's uninsured or underinsured is going to be the next big wave. Even when services are available, people can't always access them quickly."

Resource Awareness

"The information sharing is so important. Healthcare workers don't have to know everything, but if they can at least connect people to 211 or know where to go, that's critical. It's not about memorizing every resource but being able to connect people to what exists."

Prescription Affordability

"It's hard to have empathy if you've never had to make the decision between whether or not you take your heart medicine or you eat today. Those are the kinds of choices families are making."

Older Adult Needs

"Ten years ago, we knew our community was aging. The growth was on that end, but our social services haven't caught up. Seniors, often on fixed incomes, are struggling the most to keep pace with housing, healthcare, and medications."

Behavioral Health: Mental Health and Substance Use Disorder

Behavioral Health emerged as one of the more urgent and complex priorities for the Mentor Hospital community in the 2025 Community Health Needs Assessment, particularly after the COVID-19 pandemic. Interviewees consistently emphasized rising rates of depression, anxiety, and difficulty coping with daily stressors across both youth and adult populations. Schools, employers, and families alike are struggling to manage these needs, with educators and community leaders reporting that students and employees require greater mental health support. Dual diagnoses, such as developmental disabilities combined with mental health challenges, were highlighted as particularly difficult to manage, placing significant strain on families and service providers. Additionally, concerns about substance use—especially youth vaping, tobacco, and marijuana, were identified as ongoing challenges requiring community-wide interventions.

While Lake County benefits from a network of providers such as Crossroads Health, Signature Health, and the Adams Board, several systemic challenges limit access to behavioral health care. Among these are long wait times, workforce shortages, and funding constraints that make it difficult to sustain consistent, high-quality counseling services. Stakeholders described turnover among counselors and the difficulty of recruiting qualified professionals as major barriers to continuity of care. Stigma also continues to affect help-seeking behavior. Trust-building with providers is essential. Housing instability further compounds behavioral health issues, with organizations like Extended Housing struggling to expand supportive housing for individuals with mental health or substance use disorders due to community resistance and zoning barriers.

The following are highlights of participant feedback regarding behavioral health:

- Cost and Coverage Barriers: Families face high out-of-pocket costs for behavioral health services, with many underinsured or uninsured. Even with coverage, deductibles and copays make treatment unaffordable.

- Provider Shortages and Wait Times: Interviewees consistently pointed to a lack of mental health providers and long waits for appointments, particularly for psychiatry and counseling. Recruiting and retaining clinicians who accept Medicaid is especially challenging.

- Substance Use and Overdose Concerns: Stakeholders described growing substance use issues, especially related to opioids, fentanyl, and youth experimentation with marijuana and vaping. Overdose rates and related deaths remain a pressing concern.

- Rising Depression and Anxiety: Community members noted an increase in depression, anxiety, and trauma-related stress, particularly among youth and young adults, often exacerbated by isolation, economic instability, and social pressures.

- Youth Mental Health Needs: Schools and families are seeing a rise in stress, suicidal ideation, and other behavioral health challenges among

children and teens, with inadequate access to age-appropriate and school-based services.

- Stigma Limiting Care: Despite available resources, stigma around seeking behavioral health or addiction treatment continues to prevent individuals from accessing timely care.

- Housing and Social Stressors: Housing instability, unemployment, and financial insecurity were repeatedly cited as underlying drivers of mental health and substance use issues, worsening the cycle of poor outcomes.

- Need for Culturally Responsive Care: Participants highlighted the importance of providers who understand and reflect the cultural and social experiences of different populations to improve trust, access, and outcomes.

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

Rising depression and anxiety

"I think mental health is probably a common answer, but anxiety and depression have definitely increased, especially since COVID."

Youth mental health stressors

"Kids are experiencing more stress than ever before, and there just are not enough services tailored to youth."

Substance use and addiction concerns

"*Substance use has become a major issue, especially opioids and alcohol. We hear a lot about overdoses in the community."*

Provider and workforce shortages

"There just are not enough mental health providers to meet the need, and the ones we do have often do not accept Medicaid."

Long wait times for care

"*People can wait months to see a mental health provider. By the time they get in, the situation is often much worse."*

Stigma limiting treatment

"Stigma is still a big barrier. Many people will not seek help for mental health or addiction because they are worried about being judged."

Housing instability impacts

> *"Housing insecurity makes everything worse. You cannot address mental health or addiction if you don't know where you're going to sleep tonight."*

Need for culturally responsive care

> *"There is a lack of behavioral health services that are culturally aware. We need providers who understand and reflect the different communities here."*

Chronic Disease Prevention & Management

Based on the Mentor Hospital stakeholder interviews conducted as part of their 2025 CHNA, several pressing concerns around chronic disease prevention and management were identified by stakeholders. Participants noted that diabetes, hypertension, heart disease, and other long-term conditions remain widespread challenges for residents, with significant variation across groups. Barriers such as limited access to preventive screenings, inconsistent follow-up care, and cost-related challenges in maintaining treatment were cited as persistent drivers of poor outcomes. Stakeholders also emphasized that nutrition, physical inactivity, and lack of health education contribute to the onset and progression of chronic illness in the community.

Interviewees underscored the importance of a holistic approach to prevention and management. This includes improving access to early detection, increasing patient engagement in care plans, and expanding community-based wellness initiatives that address root causes such as food insecurity and lack of exercise opportunities. Older adults were identified as a particularly susceptible population, as many face challenges affording medications, maintaining mobility, and navigating multiple comorbidities. Stakeholders also noted that culturally tailored outreach and education are needed to build trust and ensure equal participation in chronic disease programs.
Overall, the findings point to the need for coordinated strategies that integrate healthcare, social services, and community partners. Sustained focus on prevention, access, and tailored support for at-risk groups was described as essential to reducing the long-term burden of chronic disease and improving health outcomes across Lake County.

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

- Food insecurity and affordability remain barriers.
- Limited access to fresh foods in certain neighborhoods.
- Education and awareness gaps about healthy eating.
- Cultural considerations in nutrition and lifestyle programs.

- Preventive wellness efforts are viewed as underfunded and fragmented.
- Physical activity opportunities are tied to wellness and chronic disease prevention.
- Stress management and mental wellness are closely linked to healthy lifestyles.

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

"Healthy eating is still out of reach for many families. Even if they know what they should be eating, the cost makes it hard."

"We see food deserts where fresh produce is not accessible. Convenience stores and fast food are easier to find than healthy options."

"Wellness has to go beyond just telling people to eat better. We need culturally appropriate education and support that meet people where they are."

"Exercise and nutrition are connected, but many people do not have safe or affordable ways to stay active."

"Stress, mental health, and lifestyle choices all impact wellness. You cannot address one without addressing the others."

Cancer
The following are highlights of participant feedback regarding cancer:

- High cancer prevalence in the community
- Concerns about timely screenings and diagnostics
- Financial barriers to treatment and follow-up care
- Gaps in awareness and education about risk factors
- Transportation challenges for specialty appointments
- Need for stronger support systems for patients and families
- Differences in access among uninsured and underinsured residents

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

"Many people put off screenings because of cost, even when they know they should get them."

"Transportation is a real problem when patients need to get to specialty appointments outside the county."

"There are still a lot of people who are not aware of free or low-cost cancer screening programs."

Stakeholders underscored that cancer remains a pressing chronic health condition for Mentor Hospital's community. Barriers related to affordability, transportation, and resource awareness continue to impede timely screening, diagnosis, and treatment. Addressing these gaps through enhanced community outreach, coordination with local nonprofits, and patient navigation services will be essential to improving outcomes. Stakeholders noted that strengthening preventive care and removing systemic barriers could significantly reduce the burden of cancer across Lake County.

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

- Diabetes: Stakeholders describe diabetes as one of the most pressing community health concerns, driven by diet, lifestyle, and health-related social needs such as access to affordable, healthy food. Education and self-management support were noted as critical gaps.

- Heart Disease: Heart disease was framed as both preventable and highly influenced by modifiable behaviors, including smoking, diet, and exercise. Stakeholders noted the need for ongoing prevention initiatives and stronger integration between primary care and community wellness programs.

- Stroke: Stroke was recognized as a condition closely tied to both heart health and diabetes. Participants pointed to the importance of education on early warning signs, rapid access to acute care, and the need for rehabilitation services to support recovery.

- Equal Access: Across all three conditions, participants stressed the importance of addressing differences in health outcomes, especially among older adults and low-income residents who face unique barriers to consistent management.

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

"Diabetes is everywhere in our community, but many people do not have the education or support to know how to manage it day to day."

"Heart disease is something we know we can prevent in so many cases, but we do not always reach people early enough with the right information and care."

"When someone has a stroke, time is everything, but people do not always recognize the signs or know where to go fast enough."

"Older residents on fixed incomes struggle to afford the healthier food and medications they need to manage these chronic conditions."

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:

- Rising prevalence of chronic diseases among older adults, including diabetes, heart disease, and cancer.
- Limited access to specialized geriatric care and preventive screenings.
- Transportation, cost, and mobility issues create barriers to maintaining regular care.
- Social isolation and mental health challenges increase vulnerability to poor health outcomes.
- There is a need for stronger community programs that support aging in place, including nutrition, fitness, and caregiver support services.
- Emphasis on the role of coordinated care between hospitals, primary care, and community organizations.

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

"Older adults are managing multiple conditions at once, and many do not have access to specialists who understand geriatric care."

"Transportation and affordability are huge barriers. Some seniors skip appointments because they cannot get there or worry about cost."

"Social isolation is a major issue. If people do not have support systems, their health outcomes decline more quickly."

"Preventive services and education for older adults are essential, but they need to be accessible, affordable, and consistent."

Maternal and Child Health

Stakeholders emphasized that Maternal and Child Health is a vital area of focus within the community, particularly given concerns about access, affordability, and the availability of specialized services. Conversations highlighted that mothers often face challenges in navigating prenatal care, mental health needs during and after pregnancy, and consistent pediatric follow-up for their children. Interviewees described barriers such as transportation difficulties, gaps in care coordination, and the need for expanded educational support for parents.

Participants also underscored the importance of addressing social and economic influences that directly impact maternal and child health outcomes. Food insecurity, housing instability, and lack of affordable childcare were repeatedly cited as compounding factors that heighten stress for families and limit their ability to maintain healthy routines. Stakeholders also raised concerns about differences in maternal health outcomes across different groups, underscoring the need for culturally responsive and equal approaches to care.

Finally, stakeholders suggested that stronger partnerships between hospitals, community organizations, and schools could provide greater continuity of support for families. Ideas included offering expanded parenting classes, strengthening outreach programs for prenatal and postnatal support, and providing integrated behavioral health services for both mothers and children. Collectively, the feedback reflects an understanding that maternal and child health outcomes are shaped by clinical care and the broader social and community environment that supports families.

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

- Gaps in prenatal and postnatal care access were consistently raised, with concerns about women not receiving early or consistent prenatal visits.
- Transportation barriers limit pregnant women and young mothers from accessing timely appointments and ongoing care.
- Stakeholders noted a shortage of pediatric and obstetric providers, making it difficult for families to establish consistent care.
- Mental health support for mothers, particularly around postpartum depression, was identified as an unmet need.
- Education for young mothers on nutrition, safe infant care, and child development was described as insufficient in some areas.
- Community-based support programs such as home visiting and early intervention were recognized as critical, but stakeholders felt these programs remain underutilized or underfunded.
- Concerns related to equal access were raised, particularly for low-income women and women of color, who face greater challenges navigating the system and securing adequate support.

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

"The stress that moms have with young kids is a growing issue."

"We don't have the resources or the trained staff to handle it, and then we get complaints because we weren't able to accommodate those needs."

"We're seeing more and more kids coming in with what I would call behavioral issues, though it's more related to things like autistic tendencies or Asperger's or other types of spectrum behaviors."

"There are a lot of mental health resources and just other resources for people when they need help with their child that is slow in development."

"Obviously, Cleveland Clinic is here, provides physical and mental health. So, there's a lot of resources here in the community."

Health-Related Social Needs

Stakeholder conversations for the Mentor Hospital 2025 CHNA revealed that health-related social needs are deeply intertwined with health outcomes across the community. Poverty, unemployment, housing instability, and food insecurity were identified as persistent barriers that limit access to healthcare and contribute to poorer health outcomes. Participants emphasized that these upstream determinants of health drive inequities across populations and amplify existing health conditions. Stakeholders also noted that lack of investment in local neighborhoods, limited public funding, and workforce challenges and how they compound poor health outcomes.

The following highlights key insights from stakeholder interviews regarding health-related social needs in the community Mentor Hospital serves.

- Financial Hardship: Residents experience significant economic barriers such as low wages, unemployment, and limited financial resources, which restrict access to healthcare and preventive services.
- Housing Instability: Participants described unstable or unaffordable housing as a major source of stress that contributes to poor health outcomes.
- Food Insecurity: Limited access to healthy, affordable food was described as a widespread concern, particularly among families with children and older adults.
- Transportation Barriers: Stakeholders cited lack of reliable transportation as a key issue preventing residents from accessing care and essential resources.
- Neighborhood Disinvestment: Communities were described as suffering from reduced infrastructure investment, lack of local resources, and fewer opportunities to improve long-term community wellbeing.
- Workforce Challenges: Unemployment, underemployment, and lack of training opportunities were highlighted as obstacles to economic stability and family health.

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

"We have so many families struggling to make ends meet, and healthcare just becomes another bill they cannot afford."

"Housing is one of the biggest issues in our area. If you do not have a safe and affordable place to live, it is hard to think about your health."

"People want to eat healthy, but it is not possible when the nearest grocery store is miles away and public transit is unreliable."

"The jobs that are available do not always pay enough to support a family, and that creates stress that affects health."

Overall, health-related social needs remain a critical driver of health differences in Mentor Hospital's community. Stakeholders underscored that without addressing fundamental barriers such as poverty, housing, food insecurity, and workforce limitations, efforts to improve health outcomes will have limited impact. These insights highlight the need for integrated, cross-sector solutions that address the root causes of poor health and invest in community infrastructure. Building long-term strategies that align healthcare, social services, and community partners will be essential to advancing fair and balanced health outcomes across the Mentor community.

Appendix E: Impact Evaluation

Mentor Hospital does not have a current Community Health Needs Assessment (CHNA) Impact Evaluation because the facility only recently opened in 2023. As a newly established hospital, there was no prior CHNA completed for this site, and therefore no previously identified prioritized health needs, nor measurable initiatives to evaluate at this time. Without a baseline CHNA and associated action plan, it is not possible to conduct a meaningful review of progress or outcomes.

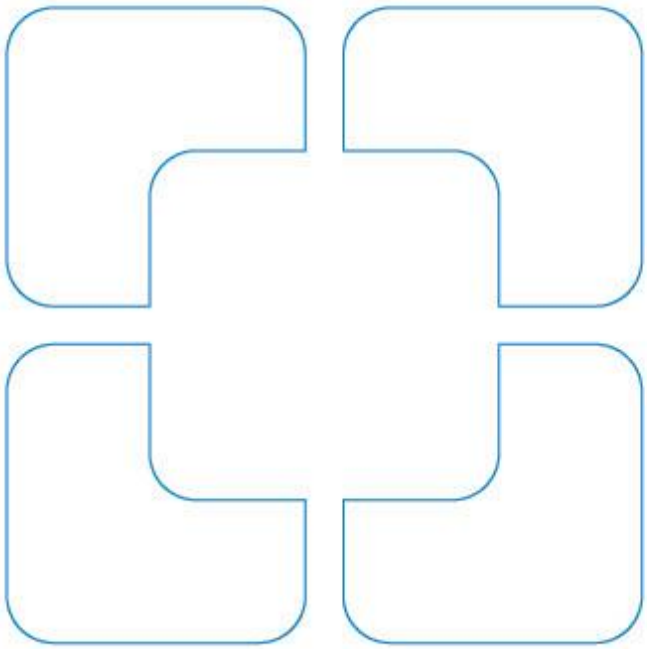
Looking ahead, Mentor Hospital is committed to ensuring full alignment with CHNA and Implementation Strategy requirements. An Impact Evaluation will be conducted as part of the next CHNA cycle, scheduled in three years. This evaluation will provide a comprehensive review of the strategies implemented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

Appendix F: Acknowledgements

Conduent Healthy Communities Institute (HCI) supported report preparation. HCI 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
Mentor Hospital

Implementation Strategy Report

2025



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

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Mentor 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 Mentor 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 Mentor 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

Mentor Hospital, a 34-bed[14] acute care facility within the Cleveland Clinic health system, newly constructed and opened in 2023 to expand access to high-quality care for Lake County residents. The hospital features four operating rooms and advanced telehealth technology that connects patients with Cleveland Clinic specialists across disciplines. The hospital offers a full continuum of inpatient, outpatient, surgical, and emergency services, along with recognized strengths in orthopedics and behavioral health.

As part of the broader Cleveland Clinic health system, Mentor 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

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

Mentor 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. 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, Mentor 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.

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

The Mentor Hospital facility was recently opened in 2023. As a newly established hospital, there was no prior CHNA or ISR.

II. Mentor Hospital Community Definition

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

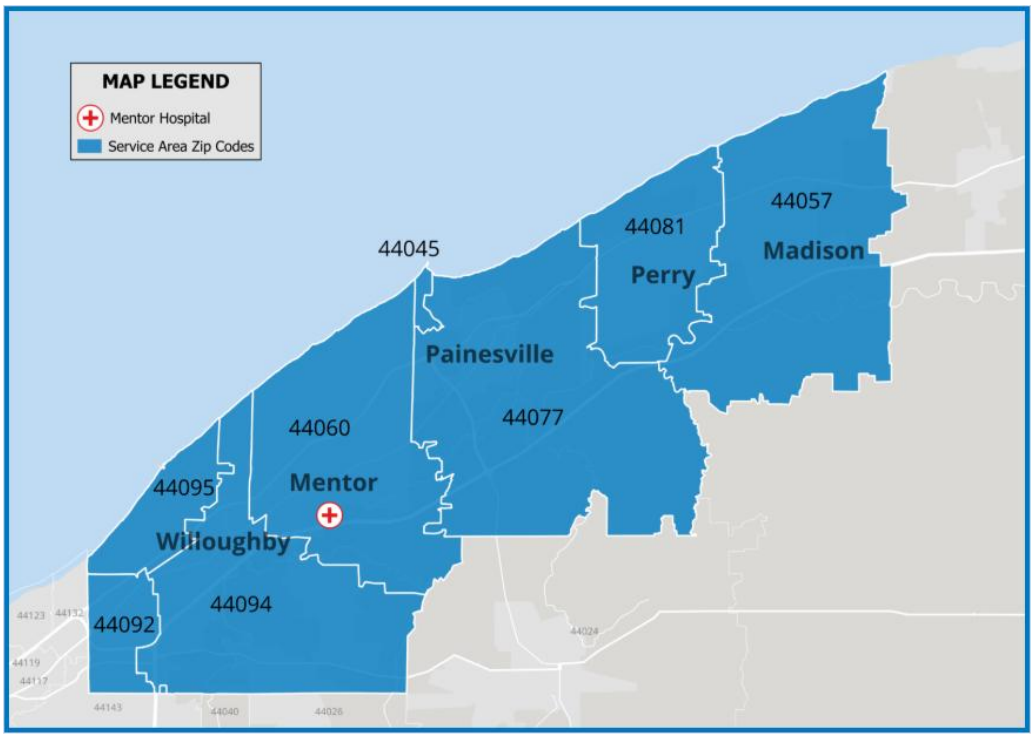


Table 1: Mentor Hospital Community Definition

Zip Code	Postal Name
44045	Grand River
44057	Madison
44060	Mentor
44077	Painesville
44081	Perry
44092	Wickliffe
44094	Willoughby
44095	Eastlake

III. How Implementation Strategy was Developed

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

Mentor 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 improve health outcomes across different populations in the community served by Mentor 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 Mentor Hospital and local nonprofit, public health, and community-based organizations. These coordinated initiatives are intended to improve health outcomes within the community the hospital serves.

A. Access to Healthcare

Access to healthcare is a significant challenge for the Mentor Hospital community, as identified in the 2025 CHNA. Stakeholders reported persistent barriers for Medicaid recipients and those with complex medical or behavioral health needs, including limited specialists accepting Medicaid, forcing residents to travel outside Lake County for care. Transportation issues, cost, and coverage gaps further restrict access, particularly for

low-income families and multi-generational households. Workforce shortages and nursing staff deficits compound these challenges. Community efforts to expand food access through partnerships were noted but remain insufficient. Data show preventable hospital stays in Lake County are 25% higher than the national rate, driven by low primary care provider availability.

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

Behavioral Health is an urgent priority for the Mentor Hospital community, as identified in the 2025 CHNA. Stakeholders reported rising rates of depression, anxiety, and stress among youth and adults, with schools and employers struggling to meet growing needs. Dual diagnoses and substance use disorder, particularly vaping, tobacco, and marijuana, were highlighted as ongoing concerns. Systemic barriers include long wait times, workforce shortages, and funding constraints, compounded by stigma and housing instability. Recommended strategies include integrated mental health and addiction services, school-based interventions, and expanded supportive housing. Data show high alcohol-related driving deaths, elevated overdose mortality, and suicide rates exceeding state and national targets.

Behavioral Health Initiatives for 2026-2028 include:

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

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

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

C. Chronic Disease Prevention and Management

Chronic Disease Prevention and Management is a key priority for the Mentor Hospital community, as identified in the 2025 CHNA. Stakeholders reported widespread conditions such as diabetes, hypertension, heart disease, and obesity, driven by barriers like cost, limited screenings, and inconsistent follow-up care. Nutrition, physical inactivity, and lack of health education were noted as major contributors, with food insecurity concentrated in certain neighborhoods. Cancer risks are high, with breast and cervical cancer rates among the highest quartile nationally. Data also show elevated hyperlipidemia and stroke risk. Older adults face added challenges, including isolation and high fall-related death rates, underscoring the need for integrated, preventive strategies.

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 reduce behavioral risk factors.

D. Maternal and Child Health

Maternal and Child Health is a key priority for the Mentor Hospital community, as identified in the 2025 CHNA. Stakeholders reported barriers to prenatal care, postpartum mental health support, and pediatric follow-up, driven by transportation challenges, care coordination gaps, and affordability issues. Social factors such as food insecurity, housing instability, and lack of affordable childcare further compound stress for families. Participants emphasized culturally responsive care and stronger partnerships between hospitals, schools, and community organizations to provide integrated supports like parenting classes, behavioral health services, and outreach programs. Data show generally favorable maternal and child health outcomes in Lake County, though differences persist as certain groups experience significantly higher mortality rates.

Maternal and Child Health Initiatives for 2026-2028 include:

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

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

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

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

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

E. Health-Related Social Needs



Health-Related Social Needs were identified as a foundational priority for the Mentor Hospital community in the 2025 CHNA due to their broad impact on health outcomes. Stakeholders cited poverty, unemployment, housing instability, and transportation barriers as persistent challenges that force families to choose between healthcare, food, and housing, creating cycles of disadvantage. Limited access to healthy food and reliable transit further compounds chronic disease and behavioral health risks, particularly for lower-income families and older adults. Participants emphasized the need for cross-sector collaboration to expand affordable housing, improve transportation, and strengthen community-based supports. While the community's median income is higher than the state average, differences persist, and social isolation is increasing, with declining rates of social associations and higher youth disconnection.

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

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

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

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

B. **Initiative:** Expand a multi-pronged strategy to address food security through education and healthy food access options. Support key partnerships with Lake County Free Clinic and Greater Cleveland Food Bank.

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

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

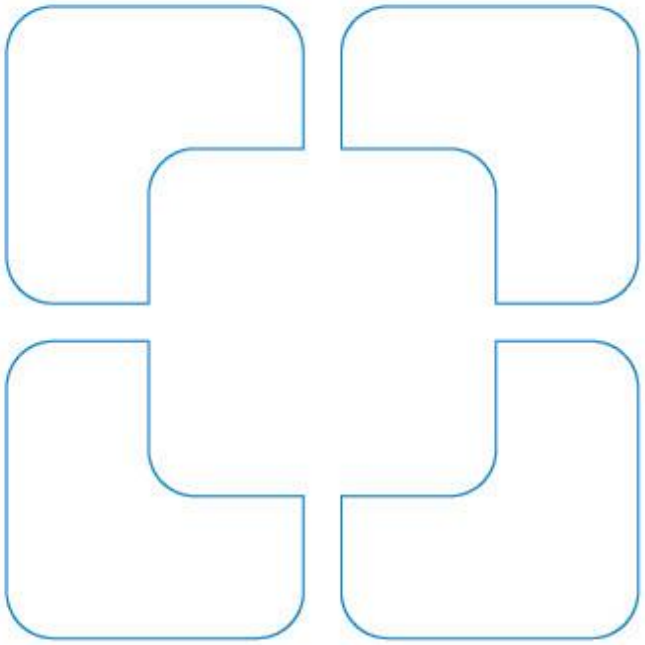
   Anticipated Impacts: Increase collaboration with community-based organizations, develop sustainable initiatives. Improve community awareness of available resources, develop a resource guide, and improve access to social supports.

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

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

While this ISR outlines specific strategies and programs identified to address the 2025 CHNA prioritized areas of Access to Healthcare, Behavioral Health, Chronic Disease Prevention and Management, Maternal and Child Health, and Health-Related Social Needs, it does not reflect all the work being done by Mentor 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 Mentor 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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