Cleveland Clinic

Community Health Needs Assessment

2022

Table of Contents

Executive Summary

This Community Health Needs Assessment (CHNA) was conducted by Cleveland Clinic Main Campus (Main Campus or "the hospital") to identify significant community health needs and to inform development of an Implementation Strategy to address current needs in accordance with the Affordable Care Act[1].

Cleveland Clinic is a non-profit multi-specialty academic medical center integrating outpatient clinical and hospital care with research and education. Cleveland Clinic is part of the social fabric of the community, creating opportunities for those around them and making the communities we serve healthier. With over 70,000 Cleveland Clinic caregivers around the world, we are one of the largest employers in Northeast Ohio and the state. We are in a unique position, along with other national academic medical centers, to assess the health needs of both our communities and the public at large and serve as a health resource for regional, national and international patients. Included in this report is a Community Health Needs Assessment for the pediatric population and community associated with Cleveland Clinic Children's (page 51).

The Main Campus is located in the City of Cleveland and is the tertiary care hospital that is the flagship of the Cleveland Clinic health system, which includes an academic medical center near downtown Cleveland, fourteen regional hospitals in northeast Ohio, a children's hospital, a children's rehabilitation hospital, five southeast Florida hospitals, and several other facilities and services across Ohio, Florida, and Nevada. The Main Campus is the location of a medical school; a research institute; 262 outpatient clinics; 20 specialty institutes, including for heart care, digestive disease, cancer, and eye care; 1,298 staffed beds[2]; and supporting labs and facilities on a 173-acre campus. Additional information about Cleveland Clinic is available at: https://my.clevelandclinic.org/.

Cleveland Clinic Children's is located on Cleveland Clinic's Main Campus in Cleveland, Ohio and has provided world-class, family-centered care to infants, children, adolescents, and families since 1921. Cleveland Clinic Children's also serves as a health resource for patients locally, regionally, nationally and internationally. Additional information on Cleveland Clinic Children's and its services is available at: https://my.clevelandclinic.org/pediatrics.

Cleveland Clinic is a global leader and model of healthcare for the future. We work as a team with the patient at the center of care. As a truly integrated healthcare delivery system, we take on the most complex cases and provide collaborative, multidisciplinary care supported with cutting-edge research and technology.

Cleveland Clinic's ability to provide world-class patient care and best-in-class clinicians is the product of our commitment to research and education, which has also contributed

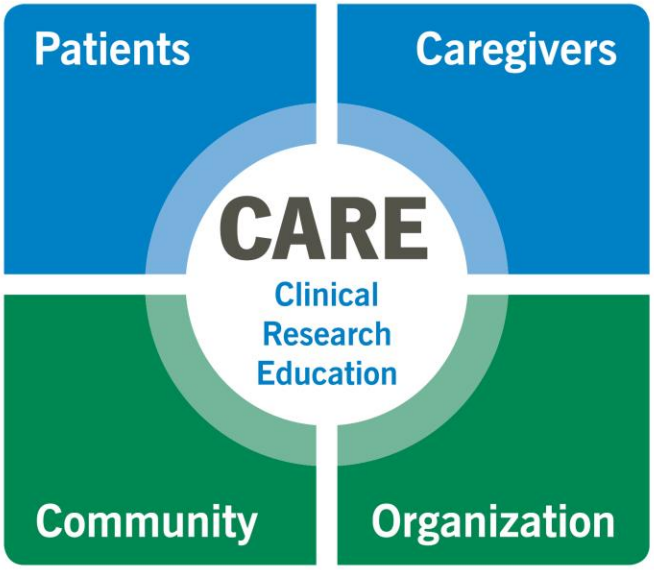
[1] Internal Revenue Service, Community Health Needs Assessment for Charitable Hospital Organizations – Section 501 (c) (3), https://www.irs.gov/charities-non-profits/charitable-organizations/requirements-for-501c3-hospitals-under-the-affordable-care-act-section-501r

[2] For the purpose of this report and consistent methodology, the Cleveland Clinic MD&A (Q4-2022) 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.

significant advancements toward the diagnosis and treatment of complex medical challenges. Figure 1 shows our Care Priorities, which are to:[3]

- Care for patients as if they are our own family
- Treat fellow caregivers as if they are our own family
- Be committed to the communities we serve
- Treat the organization as our home

Figure 1: The Cleveland Clinic Care Priorities



Caring for the Community

Caring for the community is a long-standing priority at Cleveland Clinic. As an anchor institution –a major employer and provider of services in the community –our goal is to create the healthiest community for everyone. We do this through actions and programs to heal, hire and invest for the future.

Cleveland Clinic is much more than a healthcare organization. We are listening to our neighbors to understand their needs, now and in the future. The health of every individual affects the broader community.

According to the National Academy of Medicine, only 20% of a person's health is related to the medical care they receive. There are other factors that have a lifelong impact, accounting for 80% of a person's overall health.[4] These social determinants of health are

[3] The Cleveland Clinic Mission, Vision and Values https://my.clevelandclinic.org/about/overview/who-we-are/mission-vision-values
[4] Magnan, S. Social Determinants of Health 101 for Healthcare: Five Plus Five, National Academy of Medicine. https://nam.edu/social-determinants-of-health-101-for-health-care-five-plus-five/

conditions in which people grow, work and live –including employment, education, food security, housing and several others.[5]

In order to address health disparities, we lead efforts in clinical and non-clinical programming, advocacy, partnerships, sponsorship and community investment. We are actively partnering with leaders to help strengthen community resources and mitigate the impact of disparities in social determinants of health. By engaging with partners who share our commitment, we can make a difference in creating a better, healthier community for everyone.[6]

Each Cleveland Clinic hospital is dedicated to the communities it serves. Each Cleveland Clinic hospital conducts a CHNA to understand and plan for the current and future health needs of residents and patients in the communities it serves. The CHNAs inform the development of strategies designed to improve community health, including initiatives designed to address social determinants of health.

These assessments are conducted using widely accepted methodologies to identify the significant health needs of a specific community. The assessments also are conducted to comply with federal and state laws and regulations including IRS requirements for 501(c)(3) Hospitals under the Affordable Care Act[7].

Community Definition

Cleveland Clinic Main Campus provides a wide range of services from traditional, primary care to highly specialized care to patients locally, regionally, nationally and internationally. Cleveland Clinic Main Campus treats some of the most diverse and clinically complex cases providing care in more than 120 medical specialties and subspecialties. Cleveland Clinic Main Campus provides complex specialty care to patients residing in a geographic area encompassing one quarter of the state of Ohio and to patients transferred from nearly every state and twenty countries.

For purposes of this CHNA the community definition for the Cleveland Clinic Main Campus is focused on the local geographic area immediately surrounding the hospital where community members receiving Main Campus emergency department services live. Figure 2 shows the service area for the Cleveland Clinic Main Campus Community. A table with zip codes and the associated postal names that comprise the community definition is located in Appendix C.

[5] Social Determinants of Health, World Health Organization. https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1

[6] Cleveland Clinic, Community Commitment, https://my.clevelandclinic.org/about/community#:~:text=Caring%20for%20the%20community%20is,and%20invest%20for%20the%20future.

[7] Internal Revenue Service, Requirements for 501 (c) (3) Hospitals Under the Affordable Care Act – Section 501 (r), https://www.irs.gov/charities-non-profits/charitable-organizations/requirements-for-501c3-hospitals-under-the-affordable-care-act-section-501r

Figure 2: The Cleveland Clinic Main Campus Community Definition

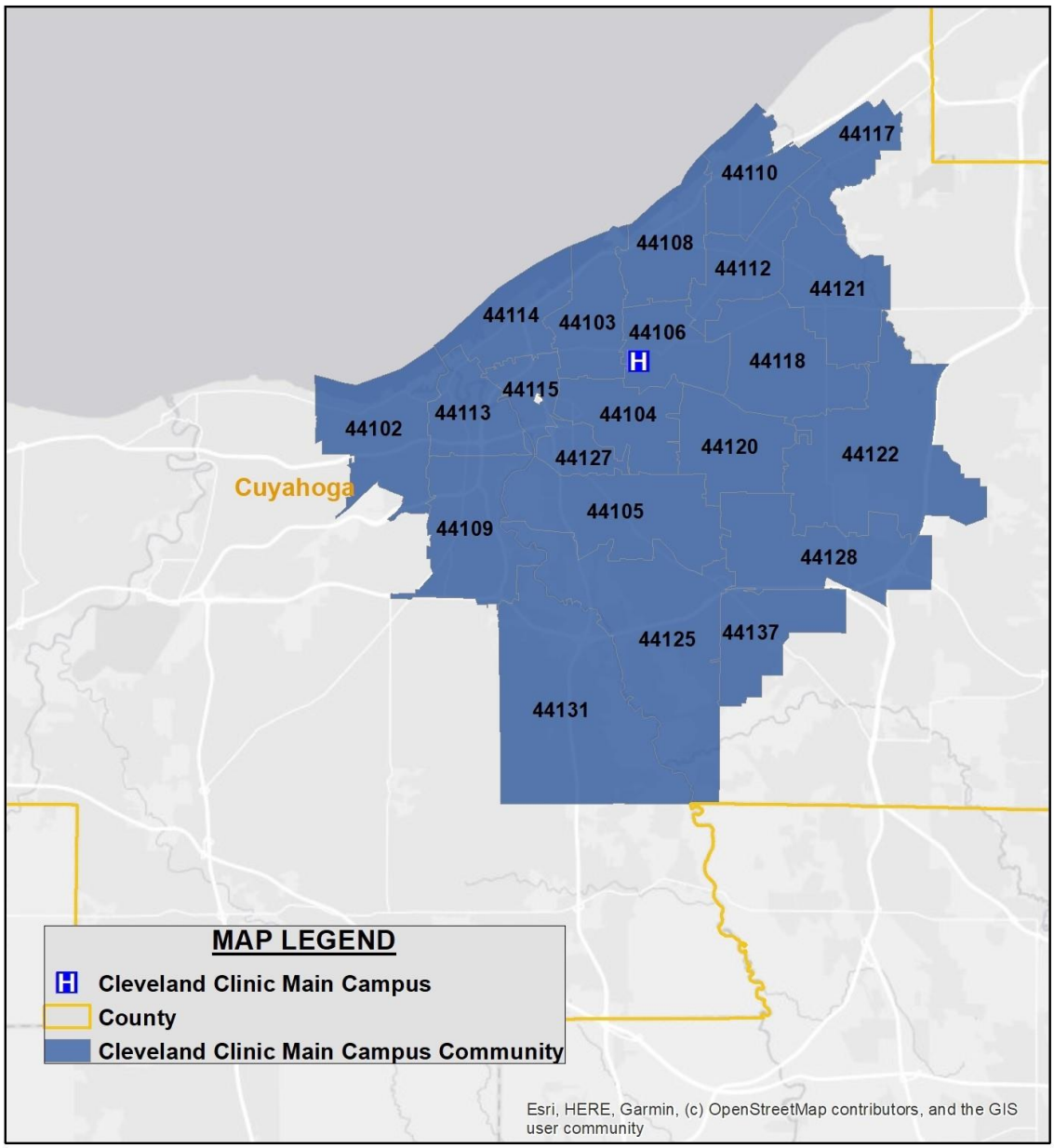
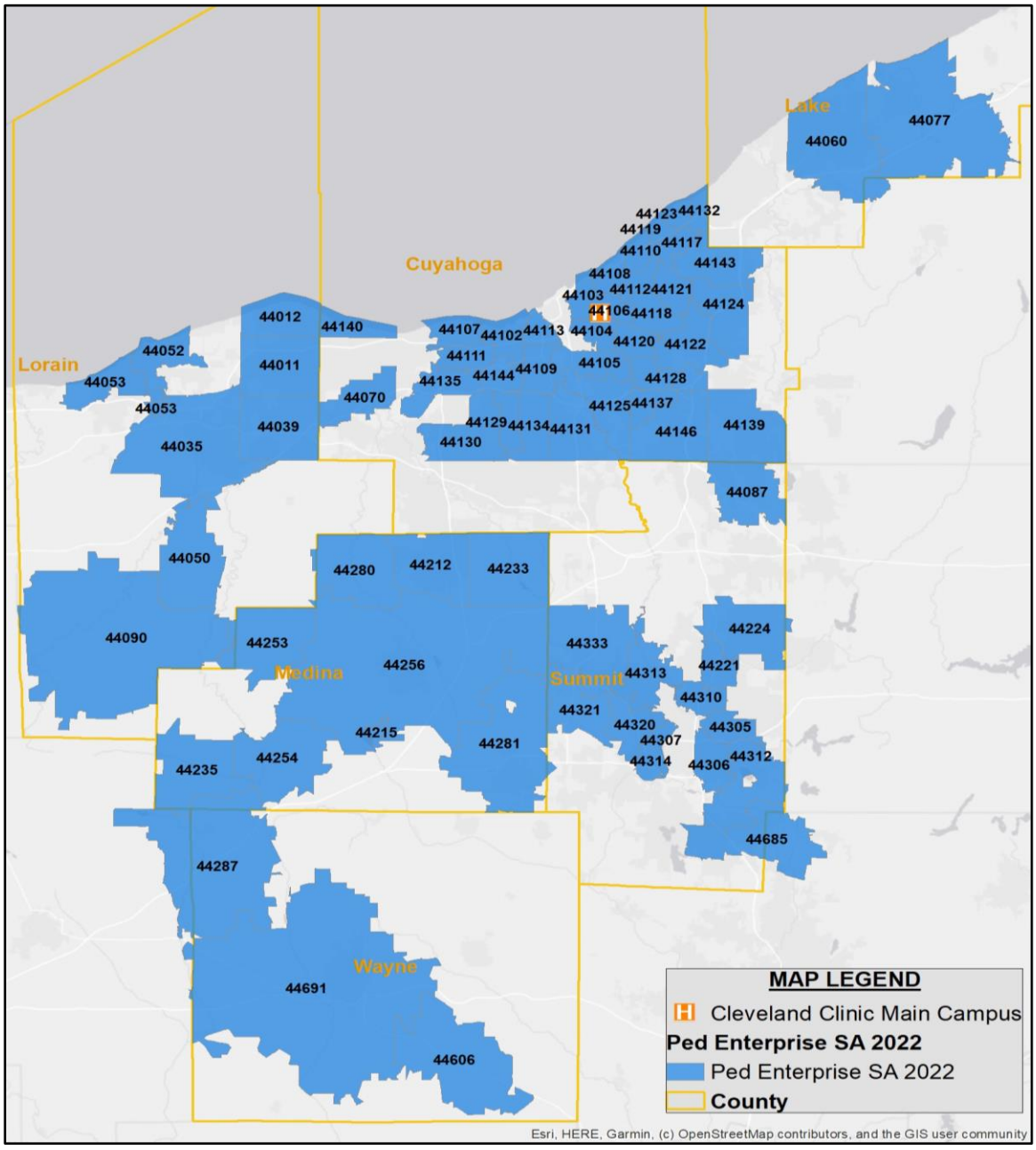


Figure 3 shows Cleveland Clinic Children's Community Definition that encompasses approximately 75% of the zip codes where patients live. A table with zip codes and the associated postal names that comprise the community definition is located in Appendix C.

Figure 3: Cleveland Clinic Children's Community Definition



Secondary Data Summary

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, social determinants of health, and

quality of life. The data are primarily derived from state and national public secondary data sources. The value for each of these indicators is compared to other communities, nationally set targets and to previous time periods.

Due to variability in which public health data sets are available, data within this report may be presented at various geographic levels:

- The Cleveland Clinic Main Campus Community Definition—an aggregate of the 22 zip codes described in the Community Definition.
- Cuyahoga County—comprising the Cleveland Clinic Main Campus Community Definition.
- The Cleveland Clinic Children's Community Definition—an aggregate of the 71 zip codes described in the Community Definition.
- Cuyahoga, Lake, Lorain, Medina, Summit and Wayne Counties—comprising the Cleveland Clinic Children's Community Definition.

Primary Data Summary

Qualitative data for Cleveland Clinic Main Campus collected from community members through key stakeholder interviews and a community engagement session comprised the primary data component of the CHNA while pediatric-focused key stakeholder inputs helped to inform qualitative data analysis for Cleveland Clinic Children's and the selection of the significant health needs.

Conduent Healthy Communities Institute interviewed 20 key stakeholders from a diverse spectrum of community-based organizations and public health departments. To provide additional support and corroboration of vital community input, the Cleveland Clinic Foundation and Conduent Healthy Communities Institute facilitated a community engagement session featuring the Stephanie Tubbs Jones Health Center Community Advisory Council (CAC) members. During the session, CAC members offered perspectives on the most important health problems in the community, barriers and challenges to improving health, identified the most underserved populations, discussed potential solutions to health challenges faced and offered success stories from existing program implementation.

Prioritized Health Needs

Following a comprehensive review of the significant community health needs throughout the Cleveland Clinic health system, analysis of local county and state needs assessments and emerging trends, the following priority health needs were identified:

- Access to Healthcare
- Behavioral Health
- Chronic Disease Prevention and Management
- Maternal and Child Health
- Socioeconomic Issues

Access to Healthcare

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

Behavioral Health

Behavioral Health encompasses two subtopics—Mental Health and Substance Use Disorder—into a single health need. Mental health secondary data indicators define suicide, Alzheimer's disease, depression and self-reported poor mental health rates. Similarly, Substance Use Disorder data outline rates related to alcohol and drug use including mortality rates due to drug overdoses. Primary data links the two together as community members and key stakeholders describe mental health challenges in the community, exacerbated by COVID-19 related stressors, resulting in increased alcohol and drug use starting in adolescence as a means of coping.

Chronic Disease Prevention and Management

This health topic encompasses several subtopics where information is available including Older Adult Health; Nutrition and Healthy Eating; Cancer; Chronic Diseases; Diabetes; Heart Disease and Stroke; and COVID-19. By addressing these issues in concert, the Cleveland Clinic Foundation hopes to impact chronic disease rates including those described in the Synthesis and Prioritization section of this report (page 34).

Maternal and Child Health

Maternal and Child Health has been a continuing health need in the community with a focus on Children's Health, Women's Health and Maternal, Fetal and Infant Health. Secondary data indicators include a range of children's health needs from babies with low birth weight to consumer expenditures on childcare. Primary data describes disparities among low-income and ethnic minority and refugee populations and link access to healthcare with pre-natal care.

Socioeconomic Issues

Socioeconomic Issues for this report are defined as a subset of social determinants of health (SDOH). Prevention & Safety, Education (K-12), Affordable Housing, Violence, Falls and Environmental Issues were the prioritized health needs described by primary and secondary data.

Additional Community Health Themes

In addition to the Prioritized Health Needs, other themes were prevalent in considering community health. These themes are intertwined in all community health components and impact multiple areas of community health strategies and delivery.

Health Equity

Health Equity issues in our communities were illuminated by COVID-19. They focus on the fair distribution of health determinants, outcomes and resources across communities.[8] Health Equity and reduction of health disparities are indicated as overarching themes in all our prioritized needs. It is described in detail and specifically as it relates to Cleveland Clinic Main Campus and Cleveland Clinic Children's (page 68) in both the Disparities and Health Equity section (page 27) of the report as well as in the Synthesis and Prioritization section (page 34). Special consideration will be given to addressing prioritized health needs through a health equity lens in the Cleveland Clinic Main Campus Implementation Strategy report.

Social Determinants of Health

Social determinants of health (SDOH) are the conditions in the environment where people are born, live, learn, work, play, worship and age that affect a wide range of health, functioning and quality of life outcomes and risks. Social determinants of health (SDOH) are major drivers of behaviors that impact individual and community health outcomes. For a full description of social determinants of health (SDOH) see the highlighted demographic section entitled Social & Economic Determinants of Health.

[8] Klein R, Huang D. Defining and measuring disparities, inequities, and inequalities in the Healthy People initiative.National Center for Health Statistics.Center for Disease Control and Prevention. https://www.cdc.gov/nchs/ppt/nchs2010/41_klein.pdf

Medical Research and Health Professions Education

Cleveland Clinic has a tripartite mission to care for the sick and to improve patient care through research and education. Through research we discover cures and treatment of diseases affecting our communities. This cross-cutting issue was evident in addressing the emergent pandemic of COVID 19. Our education programs train qualified healthcare providers to support the needs of our patients and communities, reducing healthcare access issues. This has been of historical importance to the work, care and mission of Cleveland Clinic and will continue to be incorporated as Cleveland Clinic Main Campus moves toward development of the implementation strategy report.

COMMUNITY HEALTH NEEDS ASSESSMENT

Prioritized Health Needs

- Access to Healthcare
- Behavioral Health
- Chronic Disease Prevention & Management
- Maternal and Child Health
- Socioeconomic Issues

Process

Additional Community Health Themes

Health Equity

Health Equity focuses on the fair and just distribution of health determinants, outcomes, and resources across communities.

Systemic racism
Poverty
Gender discrimination

Poorer health outcomes for groups such as Black persons, Hispanic or Latino persons, Indigenous communities, people experiencing poverty and LGBTQ+ communities.

Social Determinants of Health

Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Source: Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health

Medical Research and Health Professions Education

Cleveland Clinic has a tripartite mission to care for the sick and to improve patient care through research and education.

Through research we discover cures and treatment of diseases affecting our communities.

Our education programs train qualified healthcare providers to support the needs of our patients and communities, reducing healthcare access issues.

Demographics of the Cleveland Clinic Main Campus Community

The demographics of a community significantly impact its health profile.[9] Different racial, ethnic, age, and socioeconomic groups may have unique needs and require varied approaches to health improvement efforts. The following section explores the demographic profile of the community residing in the Cleveland Clinic Main Campus Community Definition.

Geography and Data Sources

Data are presented in this section at the geographic level of the Cleveland Clinic Main Campus Community Definition. Comparisons to the county, state, and national value are also provided when available. All demographic estimates are sourced from Claritas Pop-Facts® (2022 population estimates) and American Community Survey[10] one-year (2019) or five-year (2015-2019) estimates unless otherwise indicated.

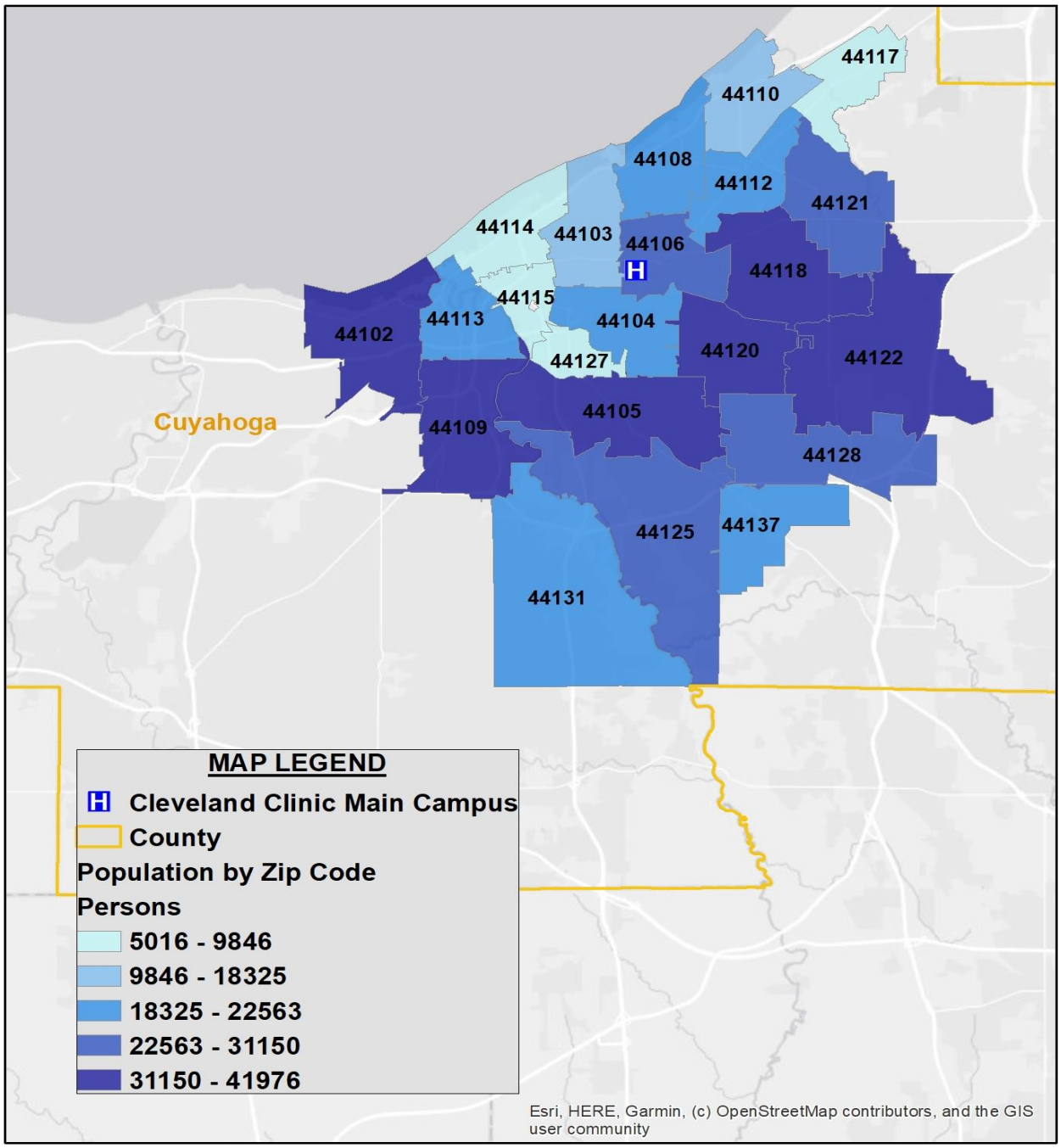
Population

According to the 2022 Claritas Pop-Facts® population estimates, the Cleveland Clinic Main Campus Community has an estimated population of 526,171 persons. Figure 4 shows the population size by each zip code, with the darkest blue representing the zip codes with the largest population. Appendix C provides the actual population estimates for each zip code. The most populated zip code area within the Cleveland Clinic Main Campus Community is zip code 44102 (Cuyahoga) with a population of 41,976.

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

[10] American Community Survey. https://www.census.gov/programs-surveys/acs

Figure 4: Population by Zip Code

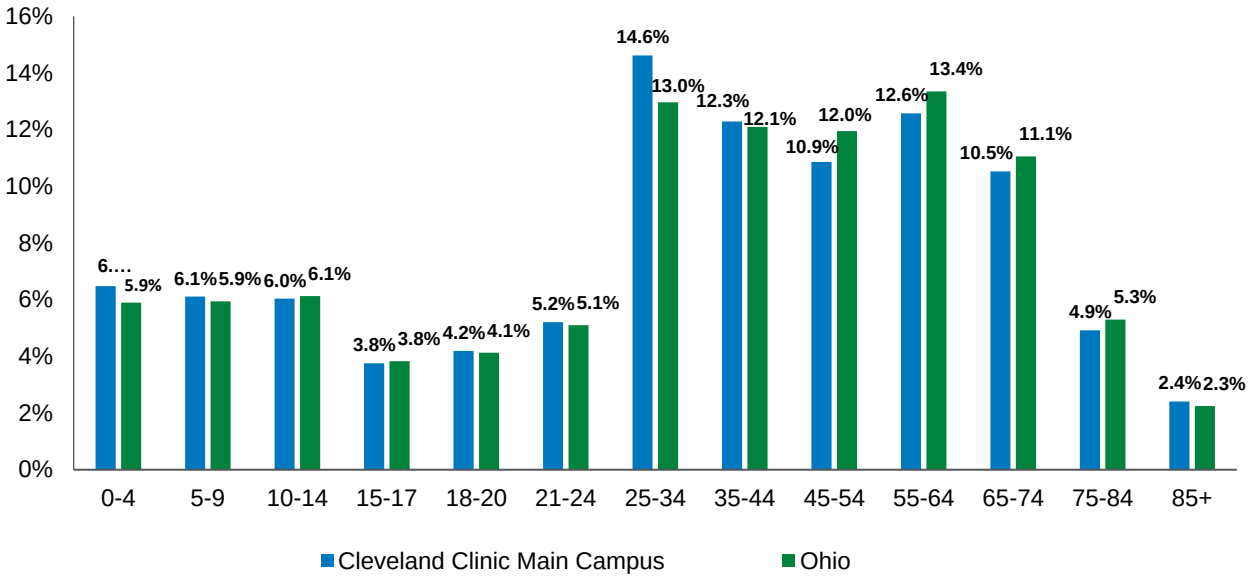


County values- Claritas Pop-Facts® (2022 population estimates)

Age

Children (0-17) comprised 22.4 % of the population in the Cleveland Clinic Main Campus Community which is higher when compared to the state of Ohio (21.8%). The Cleveland Clinic Main Campus Community has a lower percentage of residents aged 65+ (17.9%) when compared with the state of Ohio at 18.6%. Figure 5 shows further breakdown of age categories.

Figure 5: Population by Age: Hospital and State Comparisons

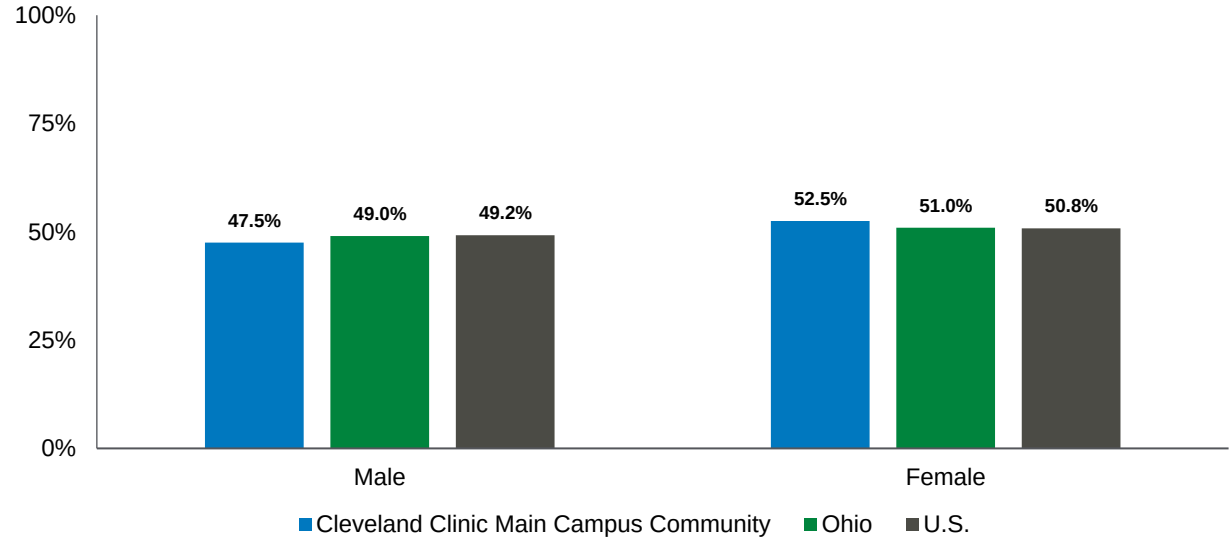


County and state values- Claritas Pop-Facts® (2022 population estimates)

Sex

Figure 6 shows the population of the Cleveland Clinic Main Campus Community by sex. Males comprise 47.5% of the population in the Cleveland Clinic Main Campus Community, which is less than both the Ohio (49.0%) and U.S. (49.2%) values. Whereas females comprise 52.5% of the population in the Cleveland Clinic Main Campus Community which is greater than Ohio (51.0%) and the U.S. (50.8%) values.

Figure 6: Population by Sex: Hospital, State, and U.S. Comparisons



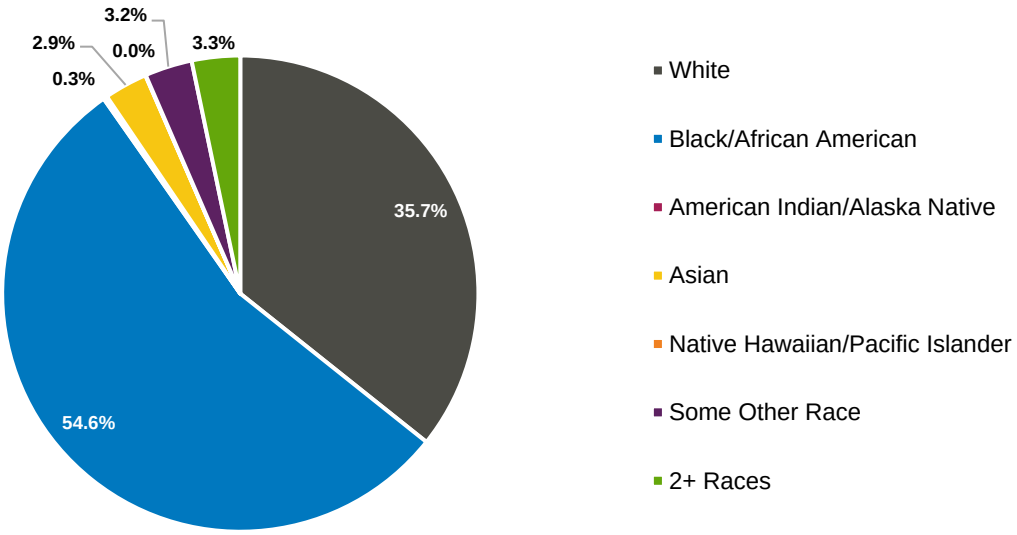
County and state values- Claritas Pop-Facts® (2022 population estimates) U.S. values taken from American Community Survey five-year (2015-2019) estimates

Race and Ethnicity

Race and ethnicity contribute to the opportunities individuals and communities have to be healthy. The racial and ethnic composition of a population is also important in planning for future community needs, particularly for schools, businesses, community centers, healthcare, and childcare.

The racial makeup of the Cleveland Clinic Main Campus Community shows 35.7% of the population identifying as White, as indicated in Figure 7. The percentage of Black/African American community members is the largest of all races in the Cleveland Clinic Main Campus Community at 54.6%.

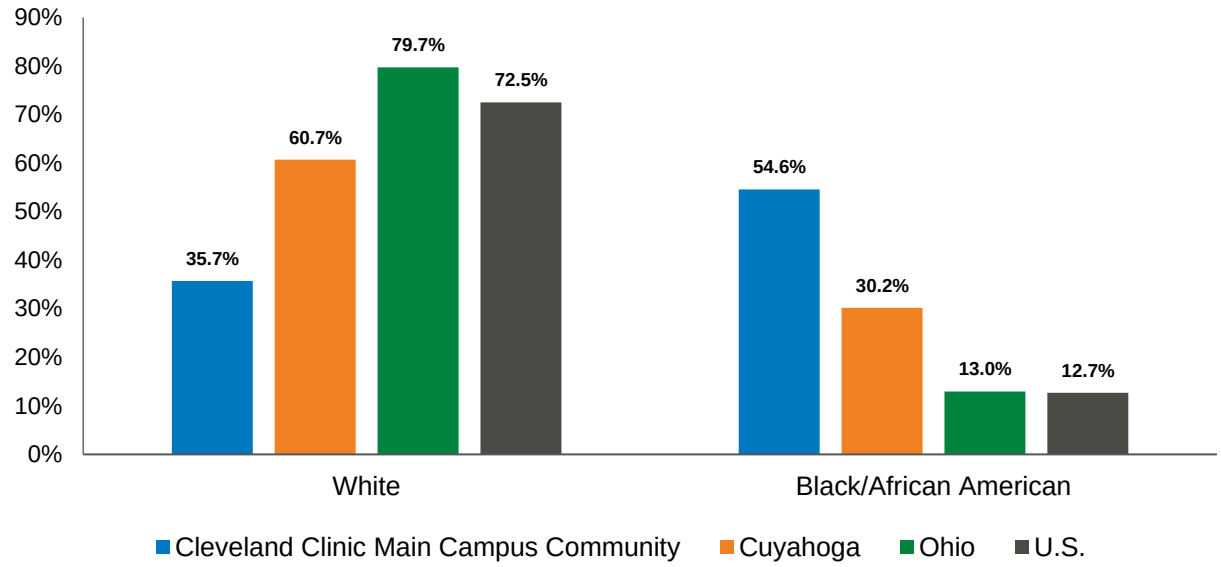
Figure 7: Population by Race: The Cleveland Clinic Main Campus Community



County values· Claritas Pop-Facts® (2022 population estimates)

Those community members identifying as White represent a lower percentage of the population in the Cleveland Clinic Main Campus Community (35.7%) when compared to Ohio (79.7%) and the U.S. (72.5%), while Black/African American community members represent a higher percentage of population in the Cleveland Clinic Main Campus Community (54.6%) when compared to Ohio (13.0%) and the U.S. (12.7%); whereas, Cuyahoga County has 30.2% of community members identifying as Black/African American. (Figure 8)

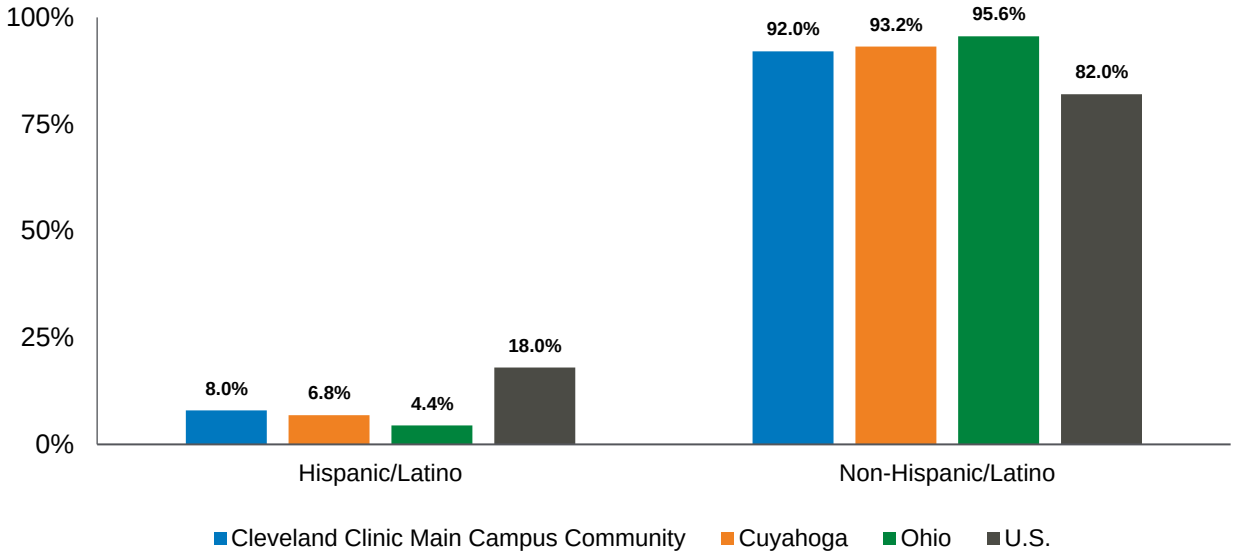
Figure 8: Population by Race: Hospital, County, State, and U.S. Comparisons



County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2015-2019) estimates

As shown in Figure 9, 8.0% of the population in the Cleveland Clinic Main Campus Community identify as Hispanic/Latino. This is a larger percentage of the population when compared to Ohio (4.4%) but smaller when compared to the U.S. (18.0%). Cuyahoga County has 6.8% of community members who identify as Hispanic/Latino.

Figure 9: Population by Ethnicity: Hospital, County, State, and U.S. Comparisons



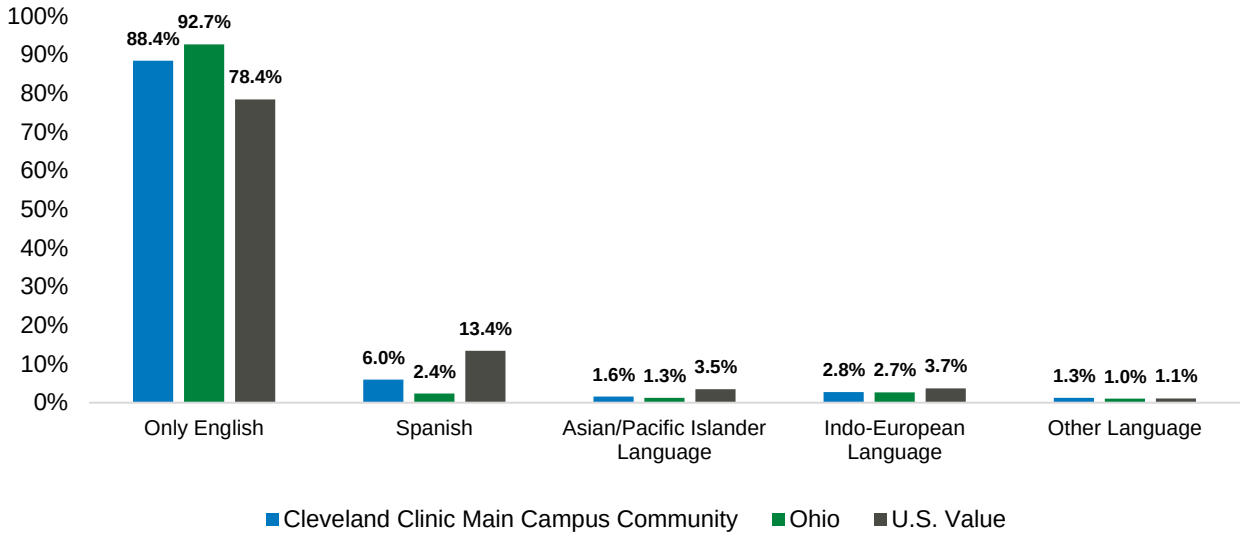
County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2015-2019) estimates

Language and Immigration

Understanding countries of origin and language spoken at home can help inform the cultural and linguistic context for the health and public health system.

In the Cleveland Clinic Main Campus Community, 88.4% of the population age five and older speak only English at home, which is lower than the state value of 92.7% but higher than the national value of 78.4% (Figure 10). This data indicates that 6.0% of the population in the Cleveland Clinic Main Campus Community speak Spanish, 1.6% speak an Asian/Pacific Islander language, 2.8% speak an Indo-European Language, and 1.3% speak Other Languages at home.

Figure 10: Population 5+ by Language Spoken at Home: Hospital, State and U.S. Comparisons



County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2015-2019) estimates

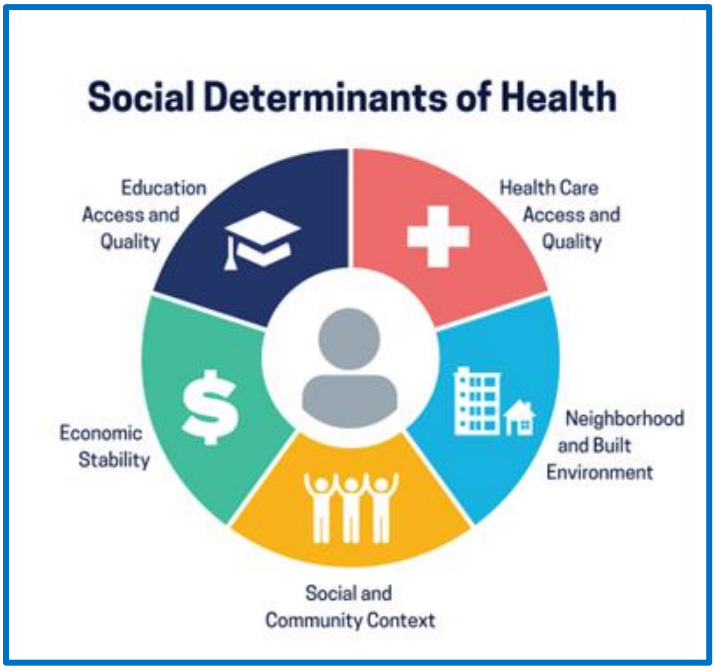
Highlighted Demographics: Social & Economic Determinants of Health

This section explores the economic, environmental, and social determinants of health impacting the Cleveland Clinic Main Campus Community. The social determinants 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[11]. The Social Determinants of Health (SDOH) can be grouped into five domains. Figure 11 shows the Healthy People 2030 Social Determinants of Health domains[12].

[11] World Health Organization. Social Determinants of Health. https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1

[12] Healthy People 2030, 2022. Social Determinants of Health Domains. https://health.gov/healthypeople/priority-areas/social-determinants-health

Figure 11: Healthy People 2030 Social Determinants of Health Domains



Geography and Data Sources

Data in this section are presented at various geographic levels (zip code and/or county) depending on data availability. When available, comparisons to county, state, and/or national values are provided. It should be noted that county level data can sometimes mask what could be going on 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 disparities.

All demographic estimates are sourced from Claritas Pop-Facts® (2022 population estimates) and American Community Survey one-year (2019) or five-year (2015-2019) estimates unless otherwise indicated.

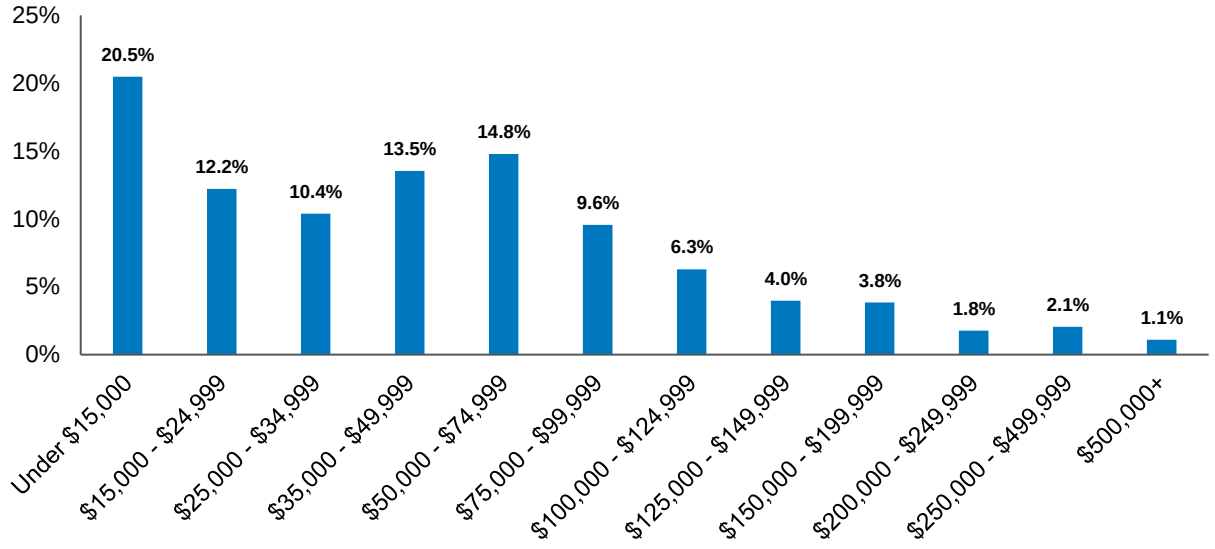
Income

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.[13]

Figure 12 provides a breakdown of households by income in the Cleveland Clinic Main Campus Community Definition. A household income of under $15,000 is shared by the largest percentage of households in the Cleveland Clinic Main Campus Community (20.5%).

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

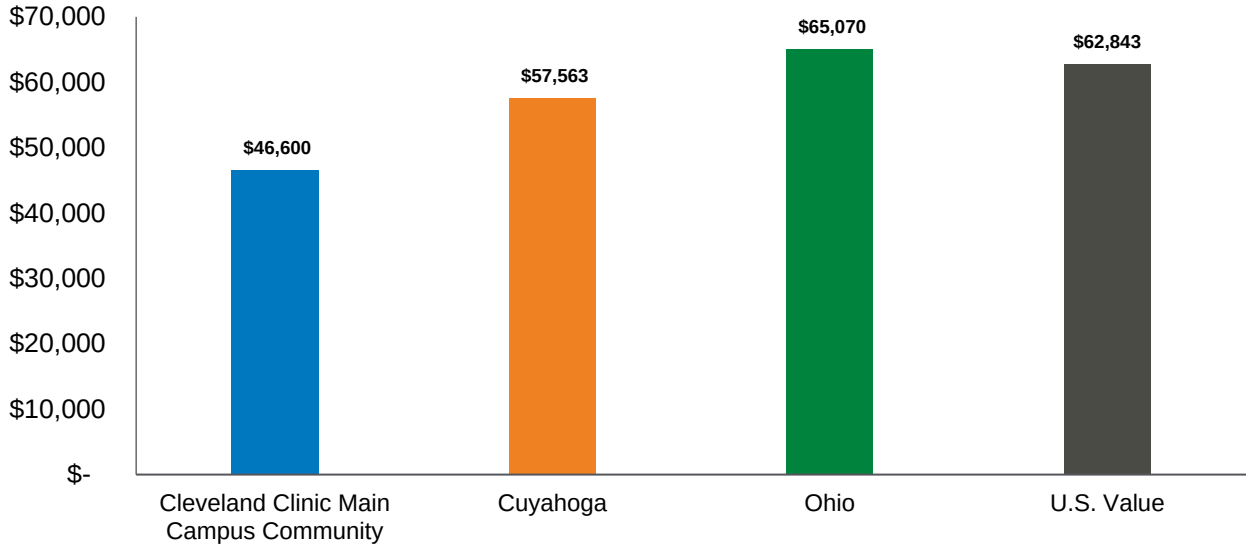
Figure 12: Households by Income: The Cleveland Clinic Main Campus Community



County values· Claritas Pop-Facts® (2022 population estimates)

The median household income for the Cleveland Clinic Main Campus Community is $46,600, which is lower than the state value of $65,070 and national value of $62,843 (Figure 13).

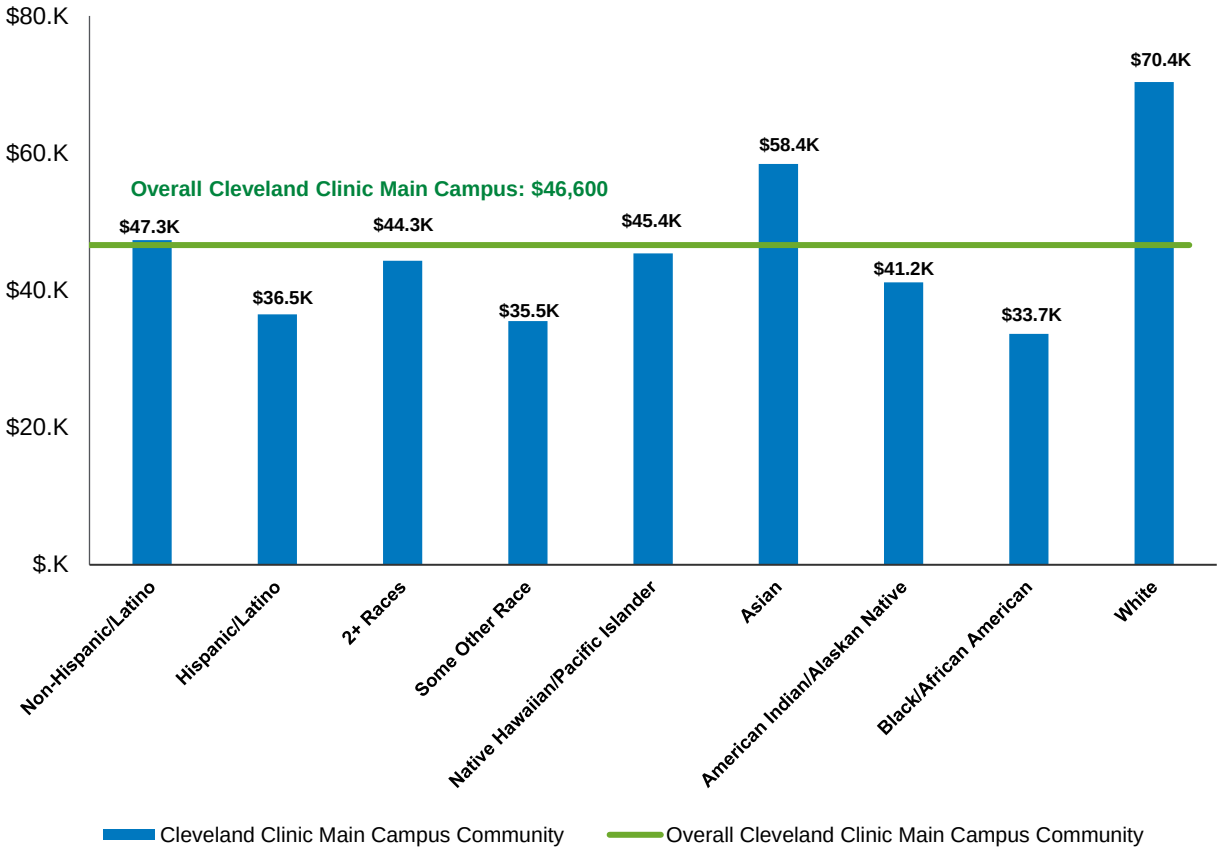
Figure 13: Household Income by: Hospital, County, State, and U.S. Comparisons



County and state values· Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2015-2019) estimates

Figure 14 shows the median household income by race and ethnicity. Three racial/ethnic groups – White, Asian, and Non-Hispanic/Latino– have median household incomes above the overall median value. All other races have incomes below the overall value, with the Black/African American population having the lowest median household income at $33,660.

Figure 14: Median Household Income by Race/Ethnicity: The Cleveland Clinic Main Campus Community



County values· Claritas Pop-Facts® (2022 population estimates)

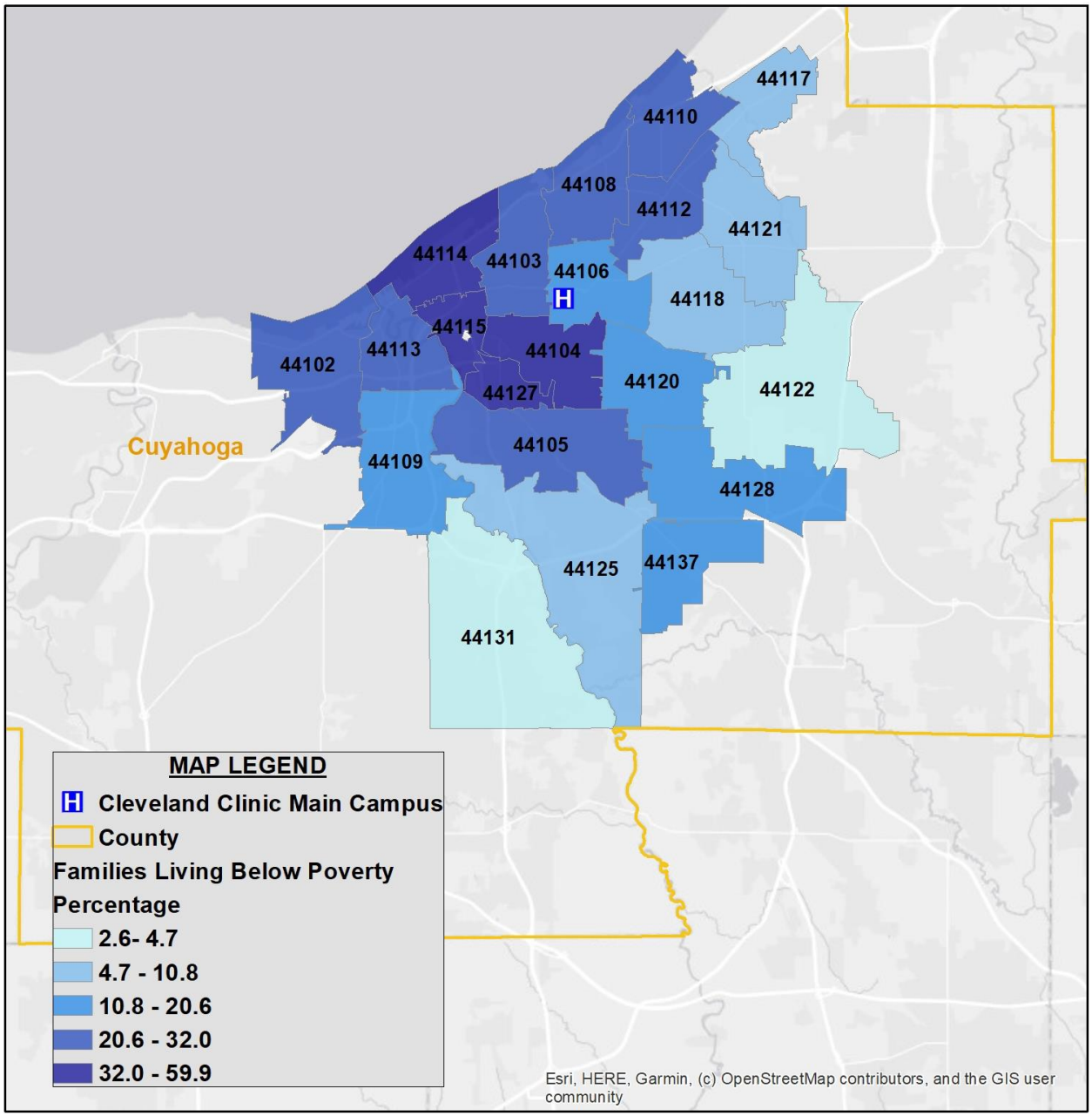
Poverty

Federal poverty thresholds are set every year by the Census Bureau and vary by size of family and ages of family members. People living in poverty are less likely to have access to healthcare, healthy food, stable housing, and opportunities for physical activity. These disparities mean people living in poverty are more likely to experience poorer health outcomes and premature death from preventable diseases.[14]

Figure 15 shows the percentage of families living below the poverty level by zip code. The darker blue colors represent a higher percentage of families living below the poverty level, with zip codes 44115 (Cleveland) and 44104 (Cleveland) having the highest percentages at 59.95% and 47.49%, respectively. Overall, 19.6% of families in the Cleveland Clinic Main Campus Community live below the poverty level, which is much higher than both the state value of 9.6% and the national value of 9.5%. The percentage of families living below poverty for each zip code in the Cleveland Clinic Main Campus Community is provided in Appendix C

[14] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/browse-objectives/economic-stability/reduce-proportion-people-living-poverty-sdoh-01

Figure 15: Families Living Below Poverty



County values- Claritas Pop-Facts® (2022 population estimates)

Employment

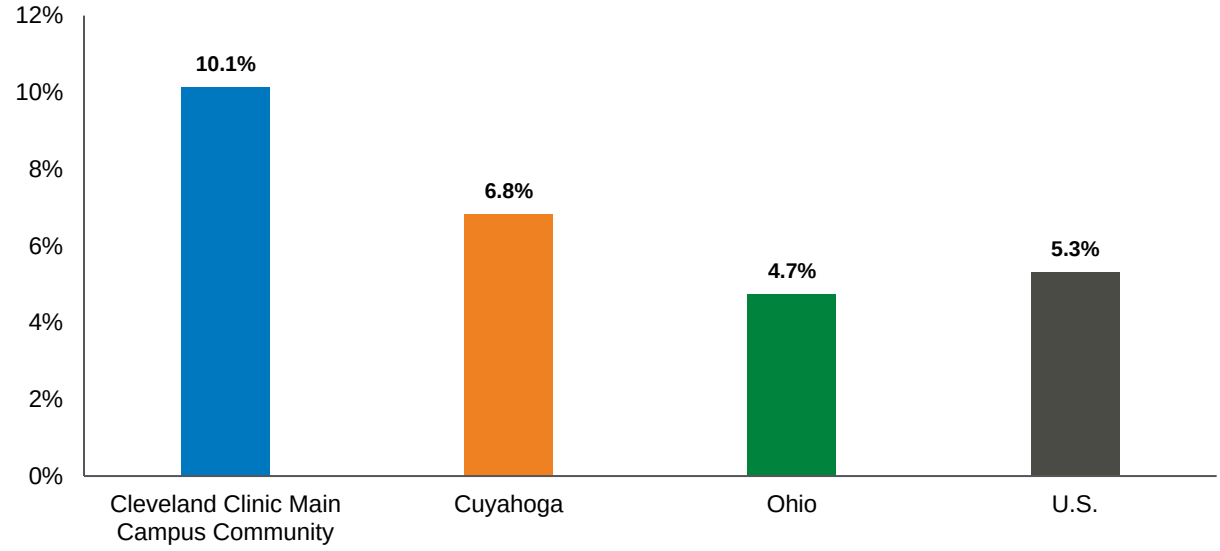
A community's employment rate is a key indicator of the local economy. An individual's type and level of employment impacts access to healthcare, work environment, health behaviors, and health outcomes. Stable employment can help provide benefits and conditions for maintaining good health. In contrast, poor or unstable work and working conditions are linked to poor physical and mental health outcomes.[15]

Unemployment and underemployment can limit access to health insurance coverage and preventive care services. Underemployment is described as involuntary part-time employment, poverty-wage employment, and insecure employment.[15]

Type of employment and working conditions can also have significant impacts on health. Work-related stress, injury, and exposure to harmful chemicals are examples of ways employment can lead to poorer health.[15]

Figure 16 shows the population aged 16 and over who are unemployed. The unemployment rate for the Cleveland Clinic Main Campus Community is 10.1%, which is much higher than the state value of 4.7% and the national value of 5.3%.

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



County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2015-2019) estimates

Education

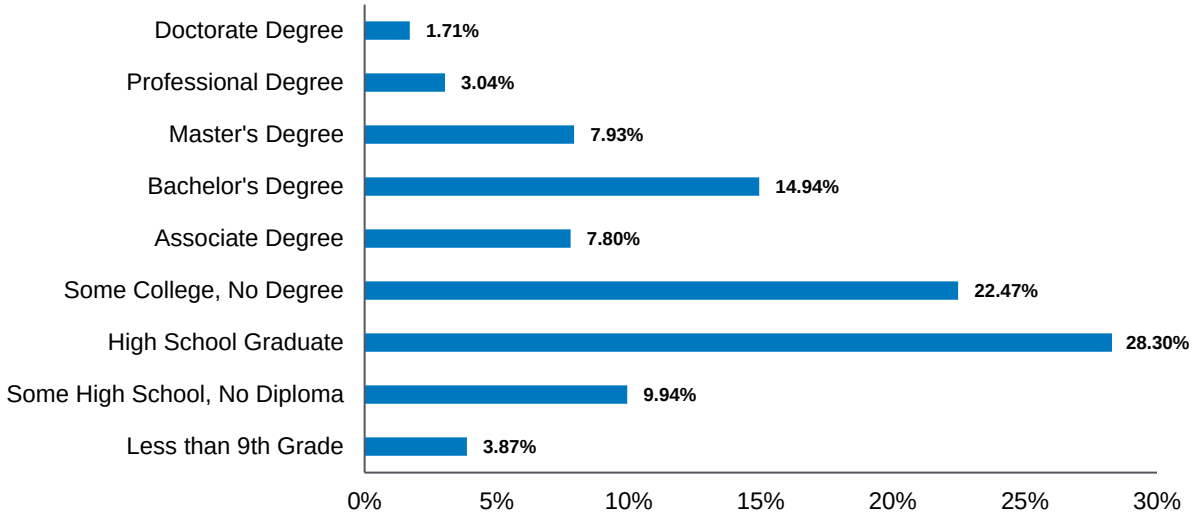
Education is an important indicator for health and wellbeing. Education can lead to improved health by increasing health knowledge, providing better job opportunities and higher income, and improving social and psychological factors linked to health. People with higher levels of education are likely to live longer, experience better health outcomes, and practice health-promoting behaviors.[16]

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

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

Figure 17 shows the percentage of the population 25 years or older by educational attainment.

Figure 17: Population 25+ by Education Attainment: The Cleveland Clinic Main Campus Community



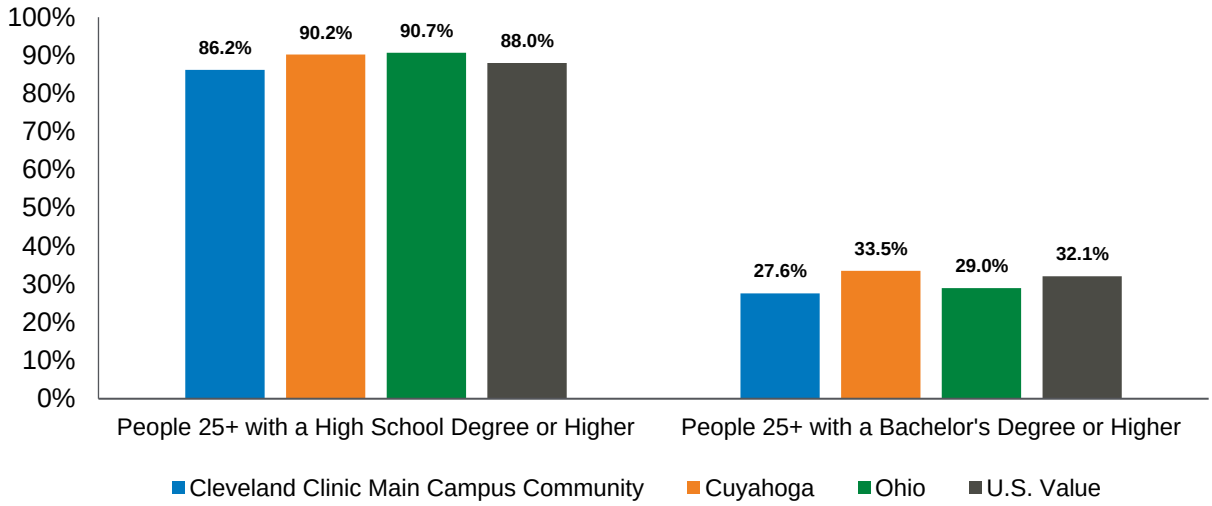
County values- Claritas Pop-Facts® (2022 population estimates)

Another indicator related to education is on-time high school graduation. A high school diploma is a requirement for many employment opportunities and for higher education. Not graduating high school is linked to a variety of negative health impacts, including limited employment prospects, low wages, and poverty.[17]

Figure 18 shows that the Cleveland Clinic Main Campus Community has a lower percentage of residents with a high school degree or higher (86.2%) and bachelor's degree or higher (27.6%) when compared to the state value (90.7% and 29.0%) and the U.S. value (88.0% and 32.1%) respectively.

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

Figure 18: Population 25+ by Education Attainment: Hospital, County, State, and U.S. Comparisons



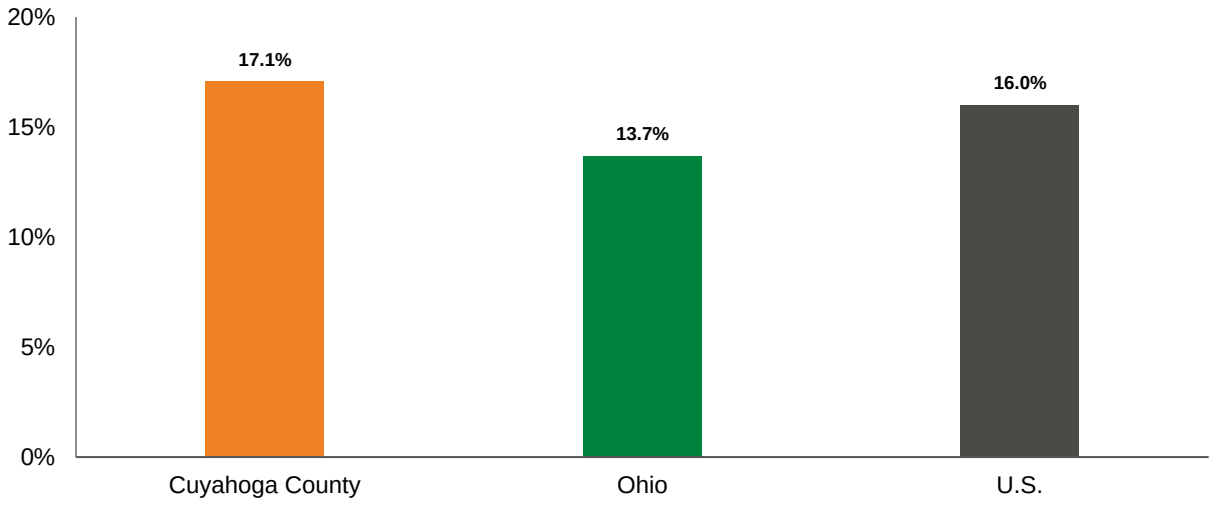
County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2015-2019) estimates

Housing

Safe, stable, and affordable housing provides a critical foundation for health and wellbeing. Exposure to health hazards and toxins in the home can cause significant damage to an individual or family's health.[18]

Figure 19 shows the percentage of houses with severe housing problems. This indicator measures the percentage of households with at least one of the following problems: overcrowding, high housing costs, lack of kitchen, or lack of plumbing facilities. Cuyahoga County has 17.1% of houses with severe housing problems.

Figure 19: Severe Housing Problems: County, State, And U.S. Comparisons



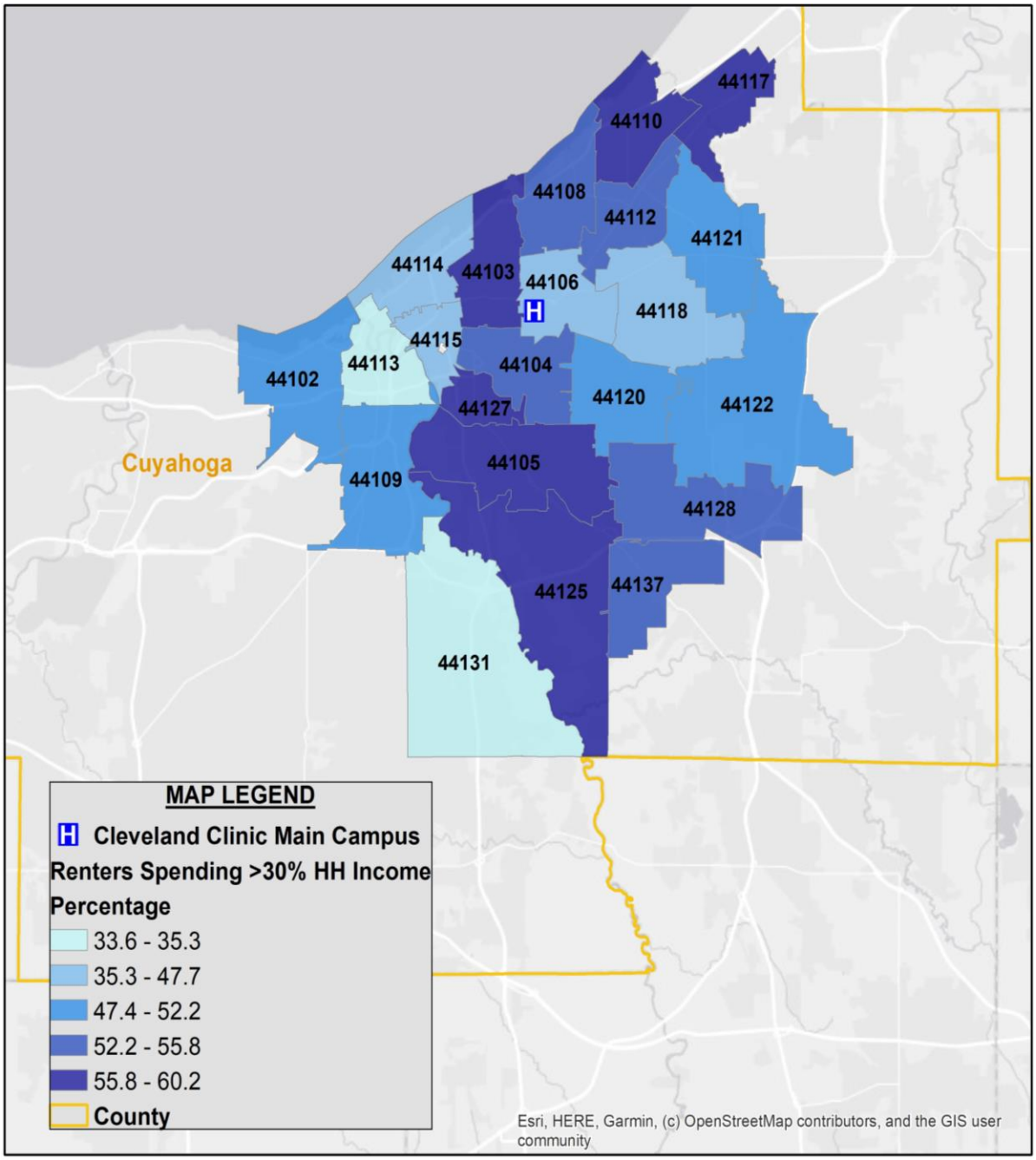
County, state values, and U.S. values taken from County Health Rankings (2013-2017)

[18] County Health Rankings, Housing and Transit. https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model/health-factors/physical-environment/housing-and-transit

When families must spend a large portion of their income on housing, they may not have enough money to pay for things like healthy foods or healthcare. This is linked to increased stress, mental health problems, and an increased risk of disease.[19]

Figure 20 shows the percentage of renters who are spending 30% or more of their household income on rent.

Figure 20: Renters Spending 30% Or More Of Household Income on Rent



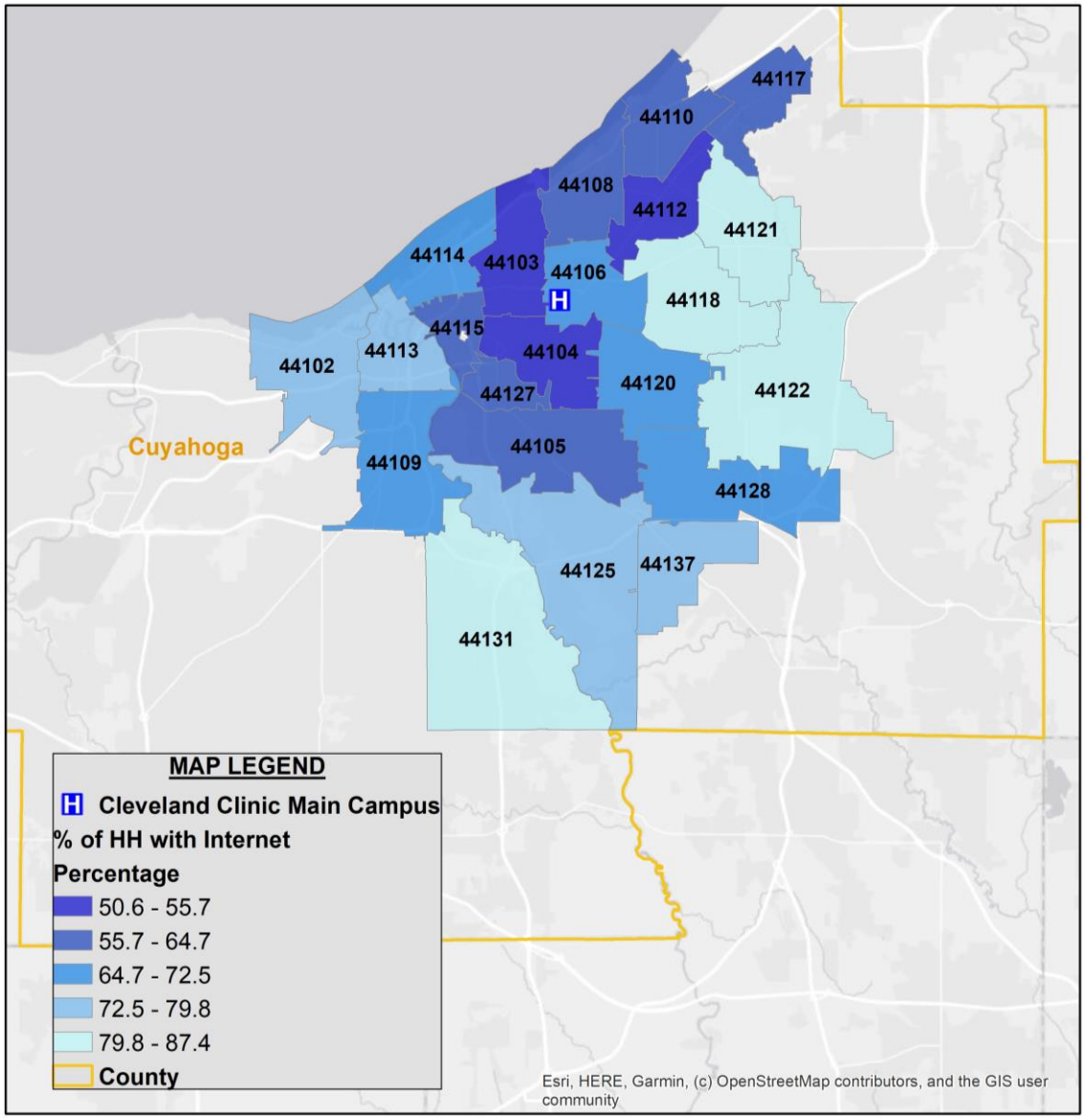
[19] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/browse-objectives/housing-and-homes/reduce-proportion-families-spend-more-30-percent-income-housing-sdoh-04

Neighborhood and Built Environment

Internet access is essential for basic healthcare access, including making appointments with providers, getting test results, and accessing medical records. Access to the internet is also increasingly essential for obtaining home-based telemedicine services.[20] Internet access may also help individuals seek employment opportunities, conduct remote work, and participate in online educational activities.[20]

Figure 21 shows the percentage of households that have an internet subscription. Zip code 44103 (Cleveland) has the lowest percentage of households with an internet subscription, represented by the darkest shade of blue on the map.

Figure 21: Households with an Internet Subscription



County values- American Community Survey five-year (2015-2019) estimates

[20] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/browse-objectives/neighborhood-and-built-environment/increase-proportion-adults-broadband-internet-hchit-05

Highlighted Demographics: Disparities and Health Equity

Identifying disparities by population groups and geography helps to inform and focus priorities and strategies. Understanding disparities also helps us better understand root causes that impact health in a community and inform action towards health equity.

Health Equity

Health equity focuses on the fair distribution of health determinants, outcomes, and resources across communities.[21] National trends have shown that systemic racism, poverty, and gender discrimination have led to poorer health outcomes for groups such as Black/African American, Hispanic/Latino, Indigenous, communities with incomes below the federal poverty level, and LGBTQ+ communities.[22]

Race, Ethnicity, Age & Gender Disparities

Primary and secondary data revealed significant community health disparities by race, ethnicity, gender, and age. It is important to note that the data are presented to show differences and distinctions by population groups. Information and themes captured through key informant interviews and community engagement session discussions have been shared to provide a more comprehensive and nuanced understanding of each community's experiences.

Secondary Data

Community health disparities were assessed in the secondary data using the Index of Disparity[23] analysis, which identifies disparities based on how far each subgroup (by race, ethnicity, or gender) is from the overall county value. For more detailed methodology related to the Index of Disparity, see Appendix A.

Table 1 below identifies secondary data indicators with a statistically significant race or ethnic disparity for the Cleveland Clinic Main Campus Community, based on the Index of Disparity.

[21] Klein R, Huang D. Defining and measuring disparities, inequities, and inequalities in the Healthy People initiative. National Center for Health Statistics. Center for Disease Control and Prevention. https://www.cdc.gov/nchs/ppt/nchs2010/41_klein.pdf

[22] Baciu A, Negussie Y, Geller A, et al (2017). Communities in Action: Pathways to Health Equity. Washington (DC): National Academies Press (US); The State of Health Disparities in the United States. Available from: https://www.ncbi.nlm.nih.gov/books/NBK425844/

[23] Pearcy, J. & Keppel, K. (2002). A Summary Measure of Health Disparity. Public Health Reports, 117, 273-280.

Table 1: Indictors with Significant Race or Ethnic Disparities

Health Indicator	Group(s) Negatively Impacted
Babies with Very Low Birth Weight	Black/African American
Children Living Below Poverty Level	Black/African American, Hispanic/Latino, Other Race
Families Living Below Poverty Level	American Indian/Alaska Native, Black/African American, Hispanic/Latino, Other Race
HIV/AIDS Prevalence Rate	Black/African American, Hispanic/Latino
People 65+ Living Below Poverty Level	Black/African American, Hispanic/Latino, American Indian/Alaska Native
People Living Below Poverty Level	American Indian/Alaska Native, Black/African American, Hispanic/Latino, Other Race, Two or More Races
Persons without Health Insurance	Hispanic/Latino, Other Race
Workers Commuting by Public Transportation	American Indian/Alaska Native, White (Non-Hispanic)
Workers who Walk to Work	Native Hawaiian/Pacific Islander
Young Children Living Below Poverty Level	Black/African American, Hispanic/Latino, Native Hawaiian/Pacific Islander, Other Race

The Index of Disparity analysis for Cuyahoga County reveals that the Black/African American, Hispanic/Latino, American Indian/Alaskan Native, Two or More Races, and Other Race group populations are disproportionately impacted by various measures of poverty, which is often associated with poorer health outcomes. These indicators include Families Living Below Poverty Level, Children Living Below Poverty Level, People 65+ Living Below Poverty Level, Young Children Living Below Poverty Level, and People Living Below Poverty Level. Furthermore, Black/African American, and Hispanic/Latino populations are disproportionately impacted in HIV/AIDS Prevalence Rate and Babies with Very Low Birth Weight.

Finally, White (Non-Hispanic), American Indian/Alaska Native, and Native Hawaiian/Pacific Islander populations are disproportionately impacted across measures of public transportation (Table 1).

Geographic Disparities

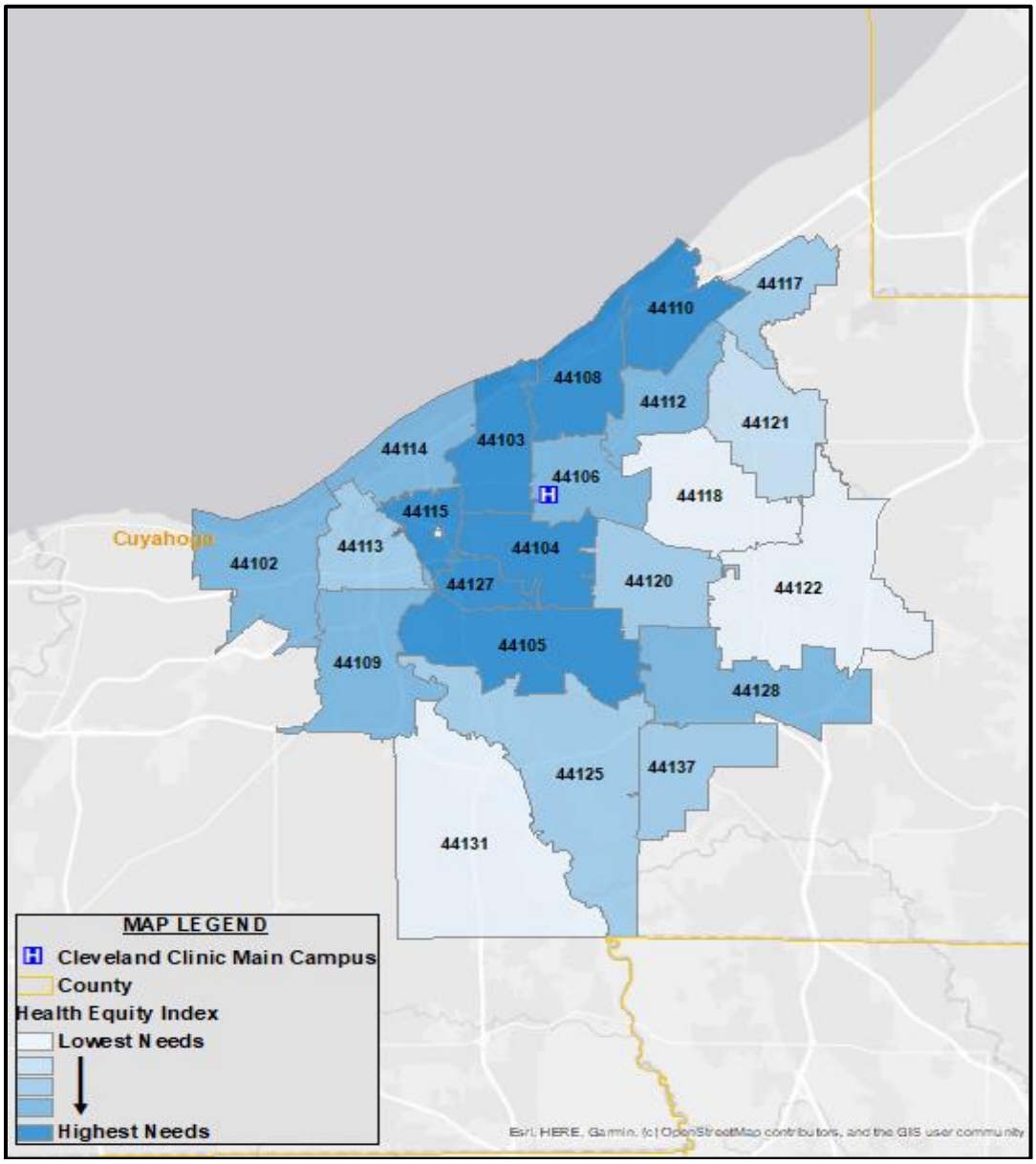
In addition to disparities by race, ethnicity, gender, and age, this assessment also identified specific zip codes/municipalities with differences in outcomes related to health and social determinants of health. Geographic disparities were identified using the Health Equity Index, Food Insecurity Index, and Mental Health Index. These indices have been developed by Conduent Healthy Communities Institute to easily identify areas of high

socioeconomic need, food insecurity and poor mental health. For all indices, counties, zip codes, and census tracts with a population over 300 are assigned index values ranging from 0 to 100, with higher values indicating greater need. Understanding where there are communities with higher need is critical to targeting prevention and outreach activities.

Health Equity Index

Conduent's Health Equity Index (HEI) estimates areas of high socioeconomic need, which are correlated with poor health outcomes. Zip codes are ranked based on their index value to identify relative levels of need, as illustrated by the map in Figure 22. The following zip codes in the Cleveland Clinic Main Campus Hospital Community had the highest level of socioeconomic need (as indicated by the darkest shades of blue): 44115, 44103, 44108, 44110, 44104, 44127, and 44105. Appendix A provides the index values for each zip code.

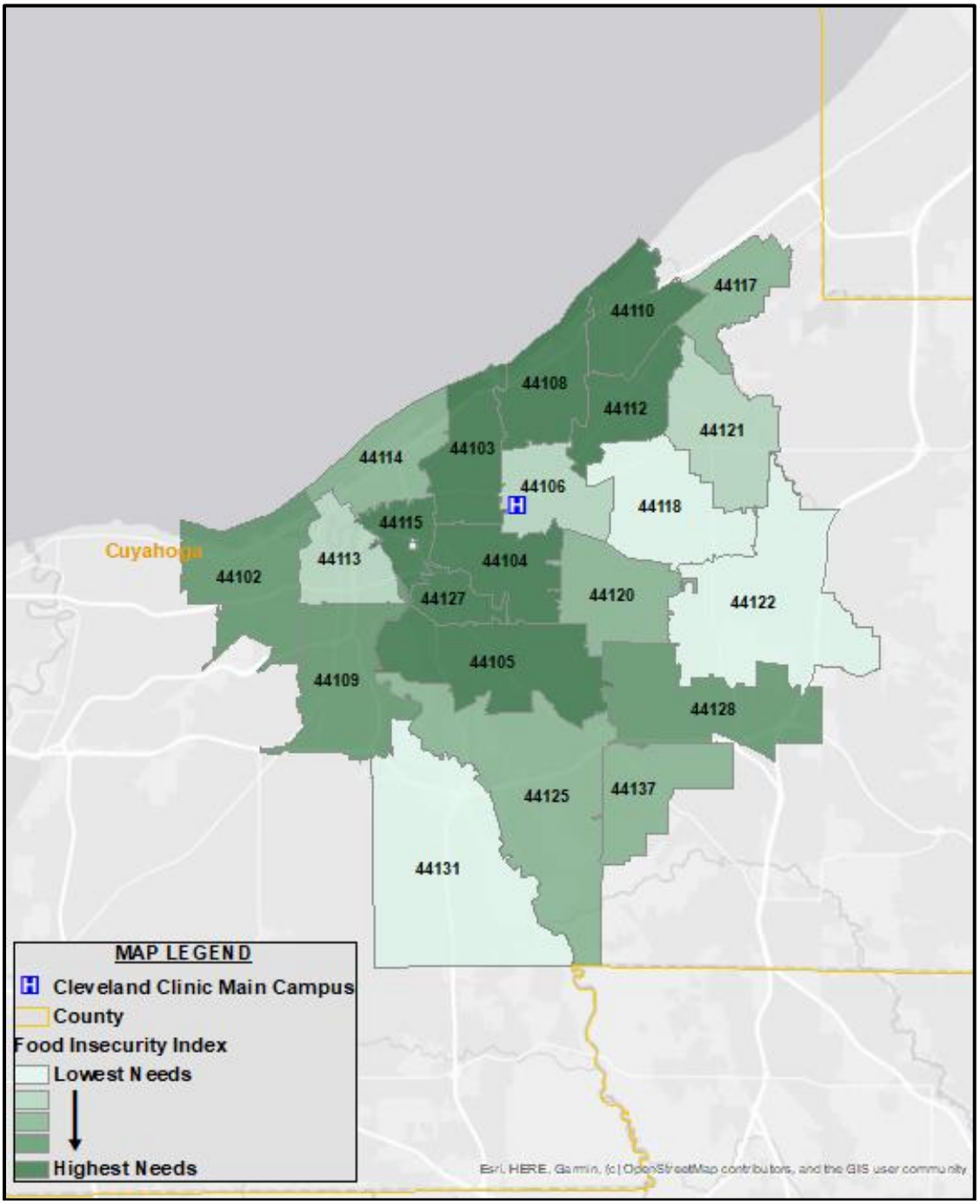
Figure 22: Health Equity Index



Food Insecurity Index

Conduent's Food Insecurity Index (FII) estimates areas of low food accessibility correlated with social and economic hardship. Zip codes are ranked based on their index value to identify relative levels of need, as illustrated by the map in Figure 23. The following zip codes had the highest level of food insecurity (as indicated by the darkest shades of green): 44115, 44127, 44105, 44104, 44103, 44108, 44110, and 44112. Appendix A provides the index values for each zip code.

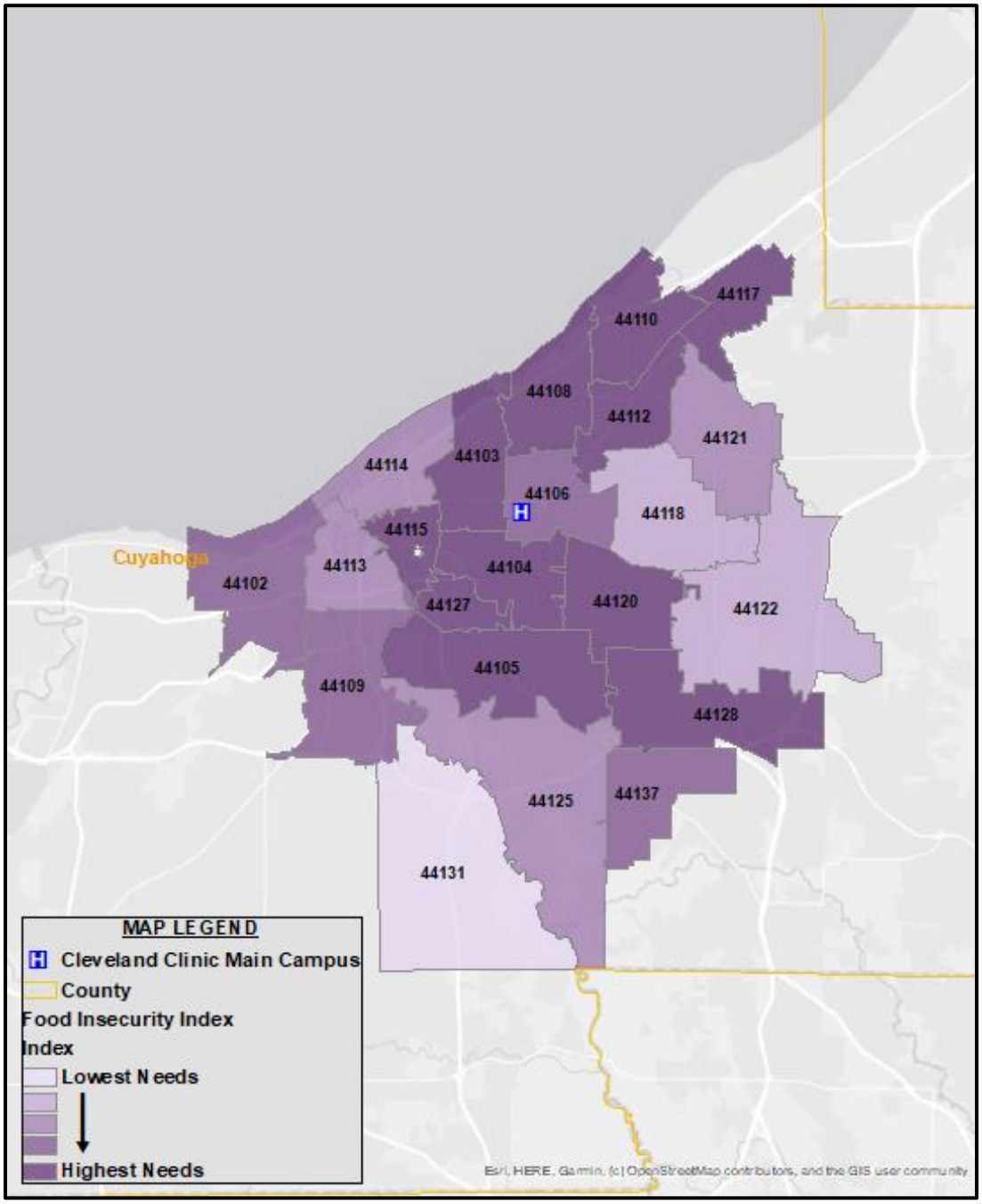
Figure 23: Food Insecurity Index



Mental Health Index

Conduent's Mental Health Index (MHI) is a measure of socioeconomic and health factors correlated with self-reported poor mental health. Zip codes were ranked based on their index value to identify the relative levels of need, as illustrated by the map in Figure 24. The following zip codes are estimated to have the highest need (as indicated by the darkest shades of purple): 44103, 44115, 44127, 44105, 44104, 44120, 44128, 44108, 44110, 44112, and 44117. Appendix A provides the index values for all zip codes within the Cleveland Clinic Main Campus Community.

Figure 24: Mental Health Index



Highlighted Demographics: COVID-19 Impacts Snapshot

On March 13, 2020, a U.S. national emergency was declared over the novel coronavirus outbreak first reported in the Wuhan Province of China in December 2019. Officially named COVID-19 by the World Health Organization (WHO) in February, WHO declared COVID-19 a pandemic on March 11, 2020. Later that month, stay-at-home orders were placed by the Ohio Governor and unemployment rates soared as companies were impacted and mass layoffs began.

At the time that the Cleveland Clinic Main Campus Community began its collaborative CHNA process, the community and the state of Ohio were in a period of the pandemic that was hoped to be in its final phases. Primary data was collected virtually to ensure the health and safety of those participating.

COVID-19 Pandemic

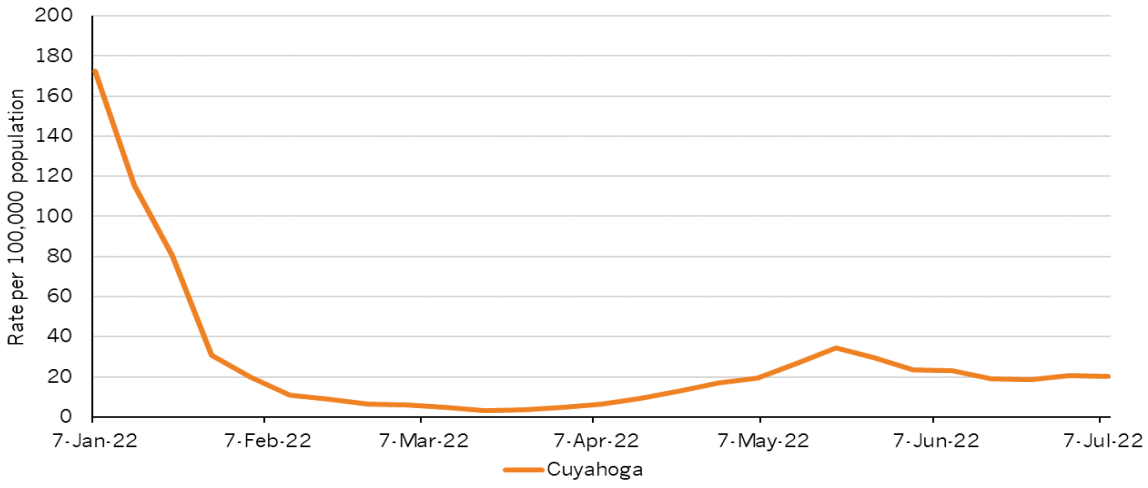
Community Input

Key stakeholder interviews and the Cleveland Clinic Main Campus Community Engagement Session served to assess the impact of the COVID-19 pandemic by asking respondents to describe how the pandemic has impacted community health outputs. Top responses focused on mental health challenges that spanned all age groups. Older adult health suffered both because of isolation borne of the fear of exposure to the COVID-19 virus, followed by sense of well-being, security, or hope, and social support/connection.

The COVID-19 Daily Average Case Incidence Rate for Cuyahoga County

Figure 25 shows the daily average COVID-19 case incidence rate for Cuyahoga County from January 2022 through early July 2022. As shown, the incidence rate has declined since the beginning of 2022, although some small spikes in incidence rates have occurred.

Figure 25: Daily Average COVID-19 Case Incidence Rate for Cuyahoga County



County values- Centers for Disease Control and Prevention (2022)

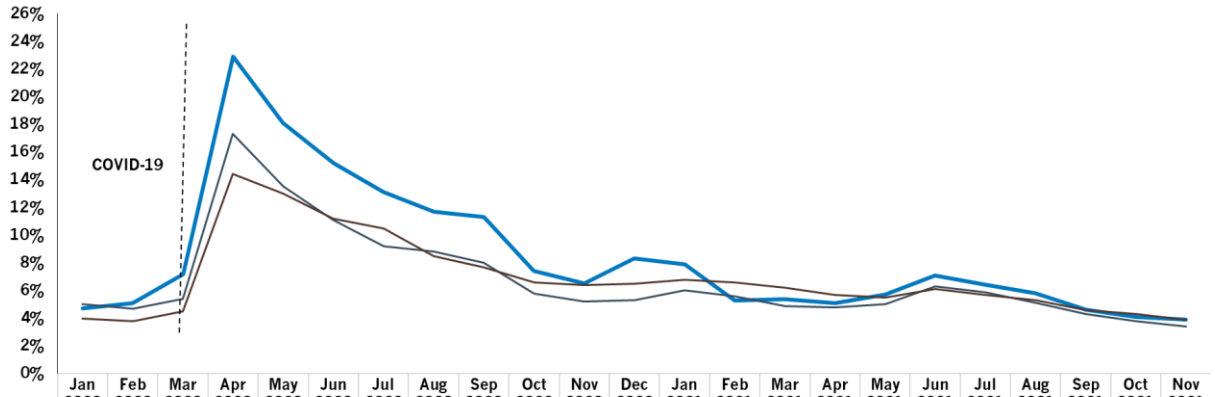
Vaccination Rates

As of June 2022, at least 64.6% of the population residing in counties within the Cleveland Clinic Main Campus Community Definition are fully vaccinated against COVID-19.

Unemployment Rates

Unemployment rates rose between March and April 2020 for Cuyahoga County when stay-at-home orders were first announced. Illustrated in Figure 26 below, as counties began slowly reopening some businesses in late-2020, the unemployment rate gradually began to go down. As of late 2021, unemployment rates have stabilized but still exceed pre-pandemic rates. When unemployment rates rise, there is a potential impact on health insurance coverage and healthcare access if jobs lost include employer-sponsored healthcare.

Figure 26: Unemployment Rate After the Start of the COVID-19 Pandemic



	Jan 2020	Feb 2020	Mar 2020	Apr 2020	May 2020	Jun 2020	Jul 2020	Aug 2020	Sep 2020	Oct 2020	Nov 2020	Dec 2020	Jan 2021	Feb 2021	Mar 2021	Apr 2021	May 2021	Jun 2021	Jul 2021	Aug 2021	Sep 2021	Oct 2021	Nov 2021
Cuyahoga	4.7%	5.1%	7.2%	22.9%	18.1%	15.2%	13.1%	11.7%	11.3%	7.4%	6.5%	8.3%	7.9%	5.3%	5.4%	5.1%	5.7%	7.1%	6.4%	5.8%	4.6%	4.1%	3.9%
Ohio	5.0%	4.7%	5.4%	17.3%	13.5%	11.1%	9.2%	8.8%	8.0%	5.8%	5.2%	5.3%	6.0%	5.6%	4.9%	4.8%	5.0%	6.3%	5.9%	5.1%	4.3%	3.8%	3.4%
U.S.	4.0%	3.8%	4.5%	14.4%	13.0%	11.2%	10.5%	8.5%	7.7%	6.6%	6.4%	6.5%	6.8%	6.6%	6.2%	5.7%	5.5%	6.1%	5.7%	5.3%	4.6%	4.3%	3.9%

County, State, and National Values- Bureau of Labor Statistics (2020-2021)

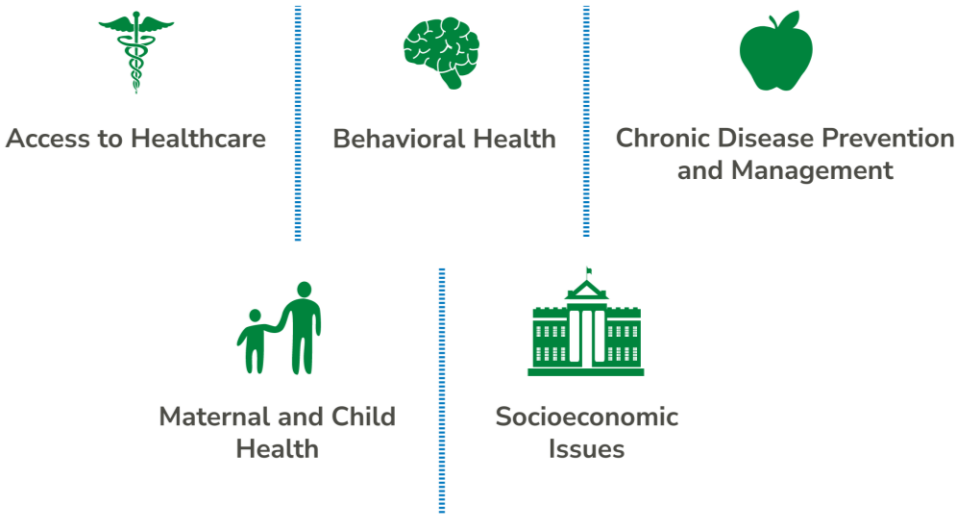
Synthesis and Prioritization

All forms of data may present strengths and limitations. Each data source used in this CHNA process was evaluated based on strengths and limitations and should be kept in mind when reviewing this report. Each health topic presented a varying scope and depth of quantitative data indicators and qualitative findings. For both quantitative and qualitative data, immense efforts were made to include as wide a range of secondary data indicators, community engagement session participants, and key stakeholders as possible. A full list of contributors can be found in the Primary Data Collection and Analysis description in Appendix A.

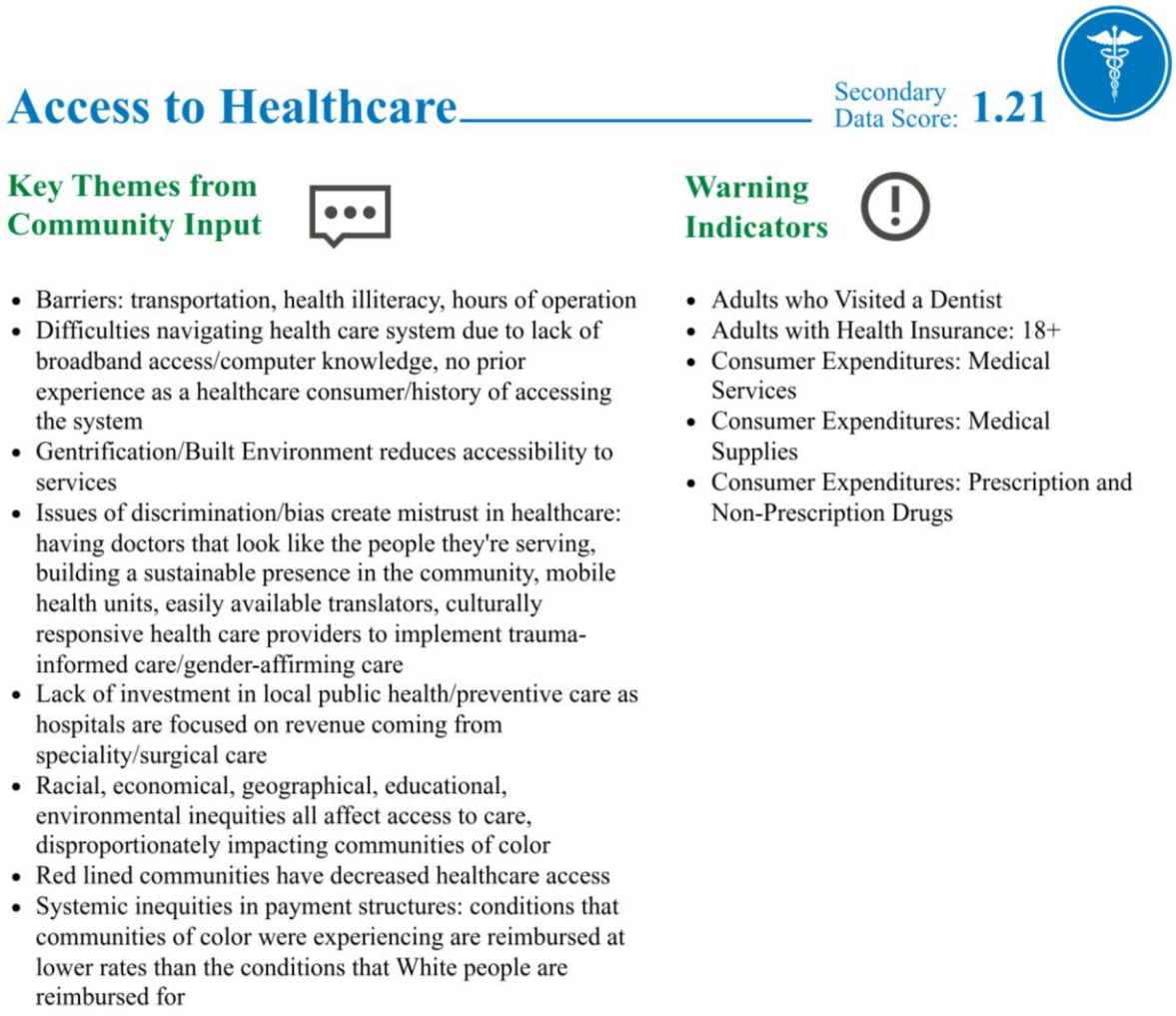
To gain a comprehensive understanding of the significant health needs for the Cleveland Clinic Main Campus Community, the findings from all three data sets were compared and studied simultaneously. The secondary data scores, community engagement session themes, and key stakeholder responses were considered equally important in understanding the health issues of the community. The top health needs identified from each of these data sources were analyzed for areas of overlap. Six health issues were identified as significant health needs across all three data sources and were used for further prioritization. To ensure alignment with state and local health department objectives, a working group analyzed these significant health needs alongside the Ohio State Health Improvement Plan (SHIP) as well as the Cuyahoga County Community Health Improvement Plans (CHIP) most recent findings. The prioritization process distilled the significant needs into five categories.

The five prioritized health needs are summarized in Figure 27. Each prioritized health topic includes the key findings from secondary data, the community engagement session discussions and key stakeholder interviews.

Figure 27: 2022 Prioritized Health Needs



Prioritized Health Topic #1: Access to Healthcare



Access to Healthcare

Secondary Data Score: 1.21

Key Themes from Community Input

- Barriers: transportation, health illiteracy, hours of operation
- Difficulties navigating health care system due to lack of broadband access/computer knowledge, no prior experience as a healthcare consumer/history of accessing the system
- Gentrification/Built Environment reduces accessibility to services
- Issues of discrimination/bias create mistrust in healthcare: having doctors that look like the people they're serving, building a sustainable presence in the community, mobile health units, easily available translators, culturally responsive health care providers to implement trauma-informed care/gender-affirming care
- Lack of investment in local public health/preventive care as hospitals are focused on revenue coming from speciality/surgical care
- Racial, economical, geographical, educational, environmental inequities all affect access to care, disproportionately impacting communities of color
- Red lined communities have decreased healthcare access
- Systemic inequities in payment structures: conditions that communities of color were experiencing are reimbursed at lower rates than the conditions that White people are reimbursed for

Warning Indicators

- Adults who Visited a Dentist
- Adults with Health Insurance: 18+
- Consumer Expenditures: Medical Services
- Consumer Expenditures: Medical Supplies
- Consumer Expenditures: Prescription and Non-Prescription Drugs

Primary Data: Key Stakeholder Interviews and Community Engagement Session

Access to Health Care was described as a top health need by the Stephanie Tubbs Jones Health Center Community Advisory Council members participating in the Community Engagement Session. Access, and access-related topics including transportation and effective navigation of healthcare and management systems were described as among the most important health problems in the community. Furthermore, lack of transportation to access medical resources, poor health education and a fear of failing to navigate the health system—including community members not knowing how to seek care from a trusted provider—were among noted barriers to improving health in the community. Community members participating in the session recommended enhancing collaborations between healthcare care and community-based organizations as well as more comprehensive city planning to benefit resource poor neighborhoods as the top ways to improve health outcomes in the community.

> Certainly the people who are living with Long COVID have very direct health care issues that they're dealing with. The pandemic has definitely led to significant delays in care early on, so a lot of that preventative stuff got pushed off and I don't think we've caught up with all that.
>
> - Key Stakeholder

Key stakeholders noted a lack of investment in prevention practices including accessibility of primary services at a local level. Racial, economical, geographical, educational, and environmental inequities all impact access to care and disproportionately affect communities of color. Three key themes surfaced from community discussions including systemic inequities in healthcare, the need to focus on preventative care, and barriers to healthcare.

Systemic inequities in healthcare included issues of discrimination and bias from providers which ultimately creates mistrust from communities experiencing this discrimination. Key informants suggested hiring providers who look like the people they are caring for, building a sustainable presence in the community, and ensuring providers are trained in trauma-informed care and gender-affirming care.

Preventative care included high utilization rates of the emergency room for minor health issues due to lack of primary care physicians, and the need to strengthen the public health infrastructure. Furthermore, COVID-19 allowed for the expansion of telehealth which increased access to healthcare for many. However, it also exposed the inequities in broadband support due to infrastructure issues leaving residents unable to access telehealth.

Barriers to healthcare included transportation, navigating a fragmented healthcare system, inability to pay for services/insurance (lack of insurance, high co-pays/deductibles), and communication challenges between providers and patients.

Secondary Data

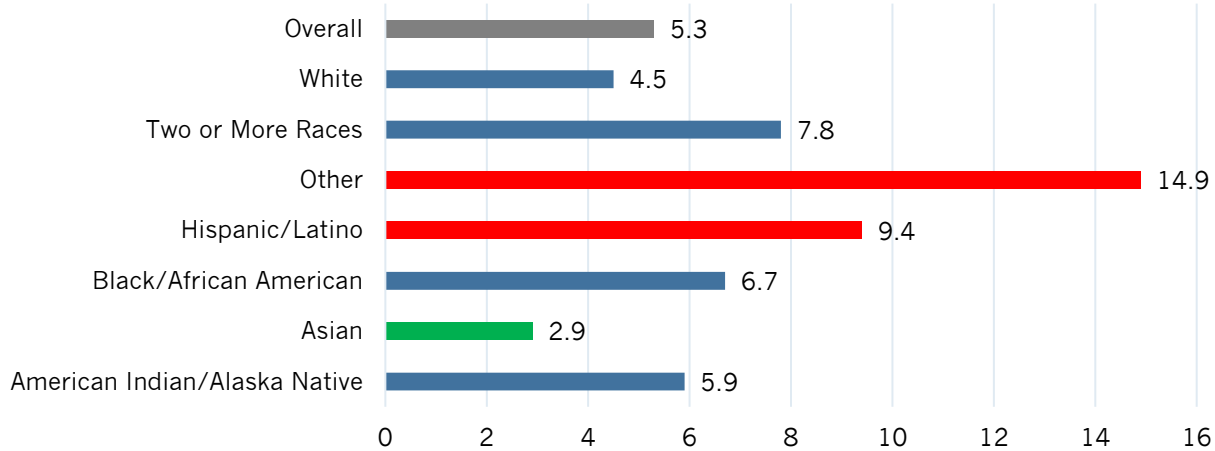
From the secondary data scoring results, Health Care Access & Quality ranked as the 16th highest scoring health need, with a score of 1.21. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and can be found in Appendix C and are discussed below. The appendices also contain a description of methodology (Appendix A) and a full list of indicators with data scoring categorized within this topic area (Appendix C).

In Cuyahoga County, 89.8% of adults have health insurance, compared to 90.6% in the United States. Medical costs in the United States are high. Therefore, people without health insurance may not be able to afford medical treatment or prescription drugs. They

are also less likely to get routine checkups and screenings, so if they do become ill, they will not seek treatment until the condition is more advanced and therefore more difficult and costly to treat. [24]Many small businesses are unable to offer health insurance to employees due to rising health insurance premiums.[25]

The rising costs of medical care and lack of insurance affects all races and ethnicities. However, in Cuyahoga County, people identifying as Hispanic/Latino and Some Other Race are disproportionately affected (see red in figure below).

Figure 28. Persons without Health Insurance by Race/Ethnicity



Source: American Community Survey, 2019

Consumer Expenditures: Medical Services ranked highly in Cuyahoga County. This indicator measures the average dollar amount spent on medical services per consumer unit. This includes expenditures on eye care, dental care, physician care, non-physician care (e.g. chiropractors, naturopaths, psychologists, midwives), lab and blood tests, x-rays, hospital rooms and related services, nursing homes/convalescent care, and other medical services. According to the secondary data, residents in Cuyahoga County spend an average of $1,057.60 on these medical services.

Similarly, Consumer Expenditures: Medical Supplies ranked highly in Cuyahoga County. Medical supplies include eyeglasses, contact lenses, hearing aids, topicals (e.g. band-aids and gauze), and other medical equipment (e.g. crutches, canes, syringes, adult diapers, and heating pads). Residents in Cuyahoga County spend an average of $199.20 on medical supplies compared to the average dollar amount of $194.90 in the United States.

[24] Kaiser Family Foundation, 2020 and 2015
[25] The Commonwealth Fund, 2019

Prioritized Health Topic #2: Behavioral Health

Behavioral Health: Mental Health

Secondary Data Score: 1.39

Key Themes from Community Input

- Closely linked with substance use as self-medication
- Housing insecurity especially for younger LGBT individuals leading to homelessness effects mental wellbeing
- Lack of meaningful investment in true community health programming
- Lack of providers to meet the increasing mental health/behavioral health needs
- Mental health issues worsened for LGBTQ+ population, children, college students, teens & teachers as a result of COVID-19 isolation
- Need to expand provider network as the justice system works to divert folks with low-level violations to treatment and mental health care
- Resources needed to help develop coping strategies & resilience from trained/supportive professionals
- Second leading cause of death in kids 10-14 is suicide
- Social isolation worsened during pandemic leading to a spike in reports of depression, anxiety, suicide attempts or death by suicide
- Transgender patients have a much higher risk of suicide due to discrimination, bigotry & isolation

Warning Indicators

- Age-Adjusted Death Rate due to Suicide
- Alzheimer's Disease or Dementia: Medicare Population
- Depression: Medicare Population
- Poor Mental Health: 14+ Days
- Poor Mental Health: Average Number of Days

Primary Data: Key Stakeholder Interviews and Community Engagement Sessions (Mental Health)

Members of the Stephanie Tubbs Jones Health Center Community Advisory Council, representing a range of organizations within the community, who attended the Community Engagement session described mental health as a top health need putting focus on creating positive outlets in the community for youth to vent frustrations and improve mental health without resorting to violence. Participants pointed to adolescents and older adults as the most underserved populations in the community. Adolescents suffered from a lack of both physical and social outlets while the COVID-19 pandemic exacerbated these and other factors contributing to poor mental health outcomes.

Key stakeholders frequently cited mental health resources, and the availability of mental health providers as disproportionate to community need. Overall, lack of mental health providers and resources, and navigation and/or knowledge about available services were all mentioned as barriers. Participants emphasized the need to examine the root causes leading to mental health issues within the community including poverty and an unequal

playing field resulting from differences in investment in education and resources for different communities. Furthermore, LGBTQ+ community members experience disproportionate mental health issues with higher risk of suicide among transgender patients. Increased experiences with discrimination, bigotry and isolation among LGBTQ+ community members were thought to contribute to these increased mental health risks. Stakeholders recommended an increase in meaningful investment in community health programming.

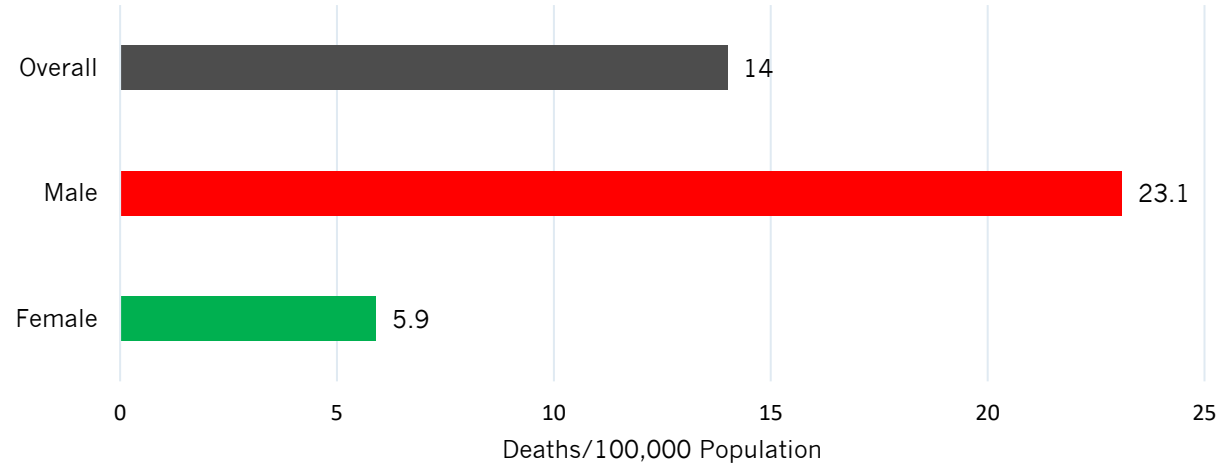
Secondary Data: Mental Health

From the secondary data scoring results, Mental Health & Mental Disorders had the 11th highest data score of all topic areas, with a score of 1.39. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and can be found in Appendix C and are discussed below. In addition, the appendices also contain a description of methodology (Appendix A) and a full list of indicators with data scoring categorized within this topic area (Appendix C).

In Cuyahoga County, 11.4% of Medicare beneficiaries have been treated for Alzheimer's Disease or Dementia and 18.5% have been treated for depression. Over the past four years, Cuyahoga County has experienced an increase in Medicare beneficiaries receiving treatment for depression.

Disparities within the mental health topic area were also found for Cuyahoga County. Although not identified as a high disparity the Age-Adjusted Death Rate due to Suicide for males in Cuyahoga County is 23.1 deaths per 100,000 population (see red), compared to 5.9 deaths per 100,000 for females (see green). This is shown in Figure 29.

Figure 29. Age-Adjusted Death Rate due to Suicide by Gender in Cuyahoga County

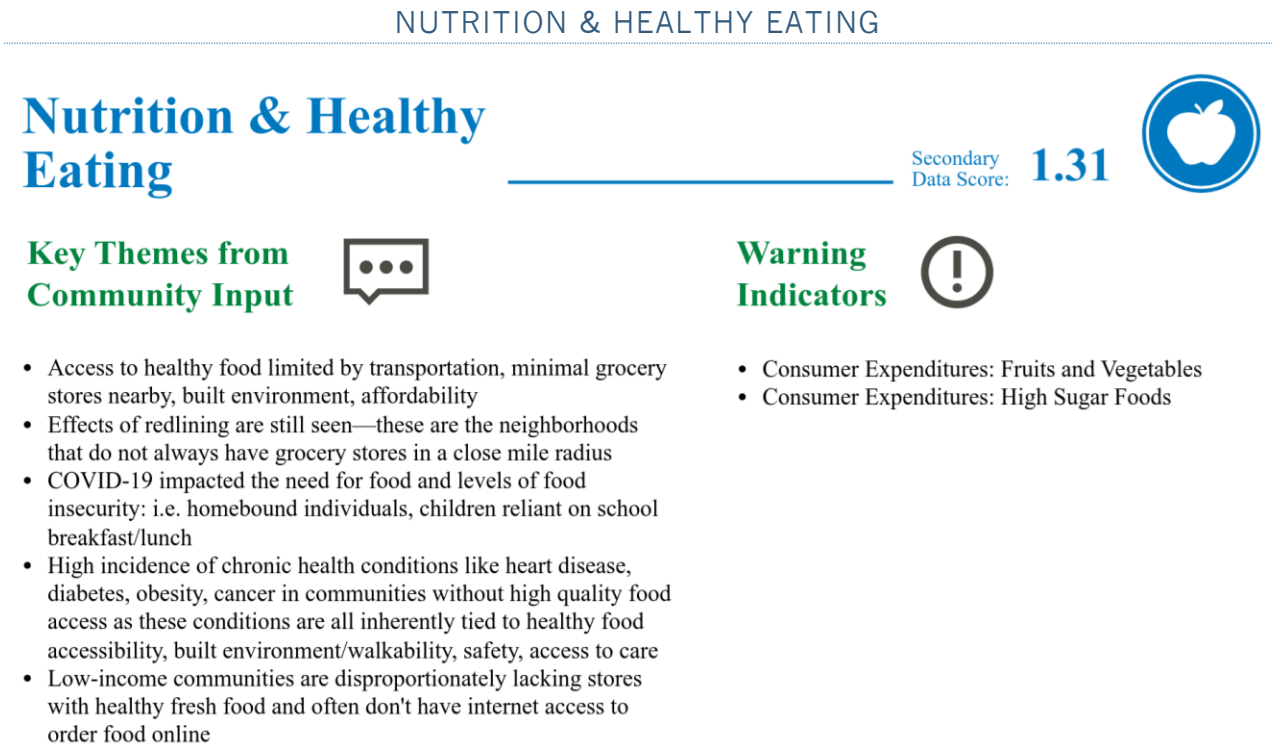


Source: Centers for Disease Control and Prevention, 2017-2019

Prioritized Health Topic #3: Chronic Disease Prevention and Management

Chronic Disease Prevention and Management is a health topic consisting of four secondary data topics – Nutrition and Healthy Eating, Chronic Diseases, Older Adult Health and Cancer. An overview snapshot of each of these subtopics is provided below.

Primary Data: Key Stakeholder Interviews and Community Engagement Session



Participants in the Stephanie Tubbs Jones Health Center Community Engagement Session described rates of diabetes and heart disease as being chronic diseases of concern in the community. Heart disease[26] and diabetes[27] are each linked to poor nutrition. Access to healthy food is contributing to the incidence and prevalence of disease in the community. Session participants commented that food deserts where neighborhoods lack grocery stores to provide fresh produce in East Cleveland—a low-income community—are of particular concern. Additionally, food pantries require additional resources to meet nutritional demands in the community and close gaps created by food deserts.

[26] Casas et al (Dec 2018). Nutrition and Cardiovascular Health, International Journal of Molecular Science. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6320919/
[27] Eat Well, Diabetes. Center for Disease Control. Well https://www.cdc.gov/diabetes/managing/eat-well.html

> To this day, the effects of redlining are still seen—these are the neighborhoods that do not always have grocery stores in a close mile radius. These are the neighborhoods where you're going to see lots of dollar stores around, where people are being forced to get their fruits and veggies because there hasn't been a historical investment in them.
>
> - Key Stakeholder

Key stakeholders corroborated sentiments expressed during the Community Engagement Session; revealing that access to healthy food was often limited by a lack of either public or private transportation. Participants shared that there were few grocery stores in the community and stores were not within walking distance for most. Those interviewed shared concerns that the effects of redlining limited access to grocery stores, which were more likely to offer fresh fruits and vegetables.

Furthermore, key informants shared concerns about seeing an increase in employees from local healthcare systems receiving services at food banks and experiencing food insecurity. Participants hoped that healthcare institutions could help to address food insecurity within the walls of their hospital. Stakeholders perceived that COVID-19 greatly impacted food insecurity in the region as seen by elevated levels of need at food banks.

Older Adult Health & Other Conditions

Secondary Data Score: 1.65 (Older Adults) 1.83 (Other Conditions)

Key Themes from Community Input

- Affordable assisted living facilities in familiar neighborhoods are scarce
- Aging at home brings increased care requirements and isolation
- Difficulties navigating health care system due to lack of broadband access/computer knowledge
- Lower income older adults disproportionately affected by chronic conditions, access to healthy food, poor housing conditions

Warning Indicators

- Adults 65+ who Received Recommended Preventive Services: Females
- Adults 65+ with Total Tooth Loss
- Adults with Kidney Disease
- Age-Adjusted Death Rate due to Falls
- Age-Adjusted Death Rate due to Kidney Disease
- Alzheimer's Disease or Dementia: Medicare Population
- Asthma: Medicare Population
- Atrial Fibrillation: Medicare Population
- Cancer: Medicare Population
- Chronic Kidney Disease: Medicare Population
- Colon Cancer Screening
- Depression: Medicare Population
- Heart Failure: Medicare Population
- Osteoporosis: Medicare Population
- People 65+ Living Alone
- People 65+ Living Below Poverty Level
- People 65+ with Low Access to a Grocery Store
- Rheumatoid Arthritis or Osteoarthritis: Medicare Population

Community Engagement Session conversations described older adults as being increasingly targets of violent crime breeding fears for their safety in the community. Older adults were described as being the top underserved populations in the community.

Key stakeholders also focused on older adults with lower incomes who are disproportionately affected by chronic conditions, access to healthy food and poor housing conditions as important issues in the community—supporting the conclusions drawn and assertions made during the Stephanie Tubbs Jones Health Center Community Engagement Session. Furthermore, participants attributed difficulties navigating telehealth services as well as arranging in-person visits to lack of broadband access or lack of comfort with technologies required to access services like smart phones, computers and tablet devices in the older adult population.

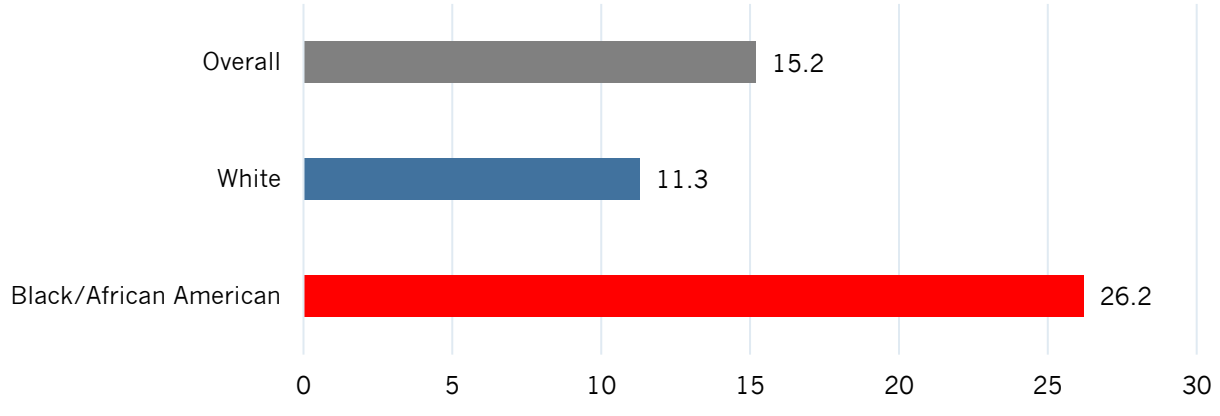
> I think one of the challenges on the healthcare side of the equation is that it is not about the quality of the care that's available, it is about a population that for many people has had no experience being a healthcare consumer. And so at least one of the challenges for folks is they have no history of accessing the system. If they get a prescription written, do they know how to get it filled? Do they know how to navigate the system to get to the pharmacy again?
>
> - Key Stakeholder

Secondary Data

Nutrition & Healthy Eating had the 14th highest data score of all topic areas with a score of 1.31. The Older Adult Health topic area had the seventh highest score at 1.65 and the related Other Conditions health topic ranked second with a score of 1.83. Older Adults and Other Conditions have scores above 1.5, demonstrating a higher need in these topics. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and can be found in Appendix C and are discussed below. In addition, the appendices also contain a description of methodology (Appendix A) and a full list of indicators with data scoring categorized within this topic area (Appendix C).

Black/African American residents of Cuyahoga County experience worse rates of Age-Adjusted Death Rate due to Kidney Disease than their White peers. Figure 30 shows Black/African Americans in Cuyahoga County have a death rate due to Kidney Disease of 26.2 deaths per 100,000 population compared to the overall rate of 15.2.

Figure 30. Age-Adjusted Death Rate due to Kidney Disease by Race/Ethnicity in Cuyahoga County



Source: Centers for Disease Control and Prevention, 2017-2019

Prioritized Health Topic #4: Maternal and Child Health

Maternal & Child Health

Secondary Data Score: 1.56

Key Themes from Community Input

- All issues are disproportionately impacting poor children
- Many AAPI (Asian American and Pacific Islander) families made the decision that their kids were safer at home, not necessarily from COVID-19, but from physical, anti-Asian hostilities. So, they kept their kids at home and that's devastating because engagement in learning is extremely difficult in that remote setting
- Opportunity for payer community to pay for food for pregnant people experiencing food insecurity to have better pregnancy outcomes
- Red lined communities are also most impacted by lead and infant mortality
- Rising behavioral health issues amongst children which was exacerbated by COVID-19
- Specialized resources need to be allocated to communities most impacted by infant mortality, prematurity, early pregnancy loss which in Cleveland, is African American families to promote true health equity
- There needs to be more intentional funding of maternal/infant health programs in the community from the hospital using an equity lens
- Top issues: lead poisoning, mental/behavioral health, infant mortality, food insecurity, delays in preventative care, learning loss

Warning Indicators

- Babies with Low Birth Weight
- Babies with Very Low Birth Weight
- Blood Lead Levels in Children (>=10 micrograms per deciliter)
- Blood Lead Levels in Children (>=5 micrograms per deciliter)
- Child Food Insecurity Rate
- Children with Low Access to a Grocery Store
- Infant Mortality Rate
- Preterm Births
- Projected Child Food Insecurity Rate
- Substantiated Child Abuse Rate
- Teen Birth Rate: 15-17
- Teen Pregnancy Rate

Primary Data: Key Stakeholder Interviews and Community Engagement Session

Maternal and Child Health has dominated community discussions for multiple assessment cycles. High maternal and infant mortality rates across communities served by enterprise hospitals have been of particular concern. Implementation strategies precipitated investments in community health focused on reducing maternal and infant mortality. During the Stephanie Tubbs Jones Health Center Community Engagement Session, single parents and mothers are described as among the most underserved populations in the community with participants insisting that more resources are needed to support the population.

Key stakeholder interviews acknowledged the persistence of high infant mortality rates as well as the continuance of lead poisoning as a contributor to poor children's health outcomes. During the COVID-19 pandemic, long periods of time spent indoors increased exposures and worsened lead related incidents and outcomes. Stakeholders noted that there is an opportunity for the payer community to pay for food for pregnant people

experiencing food insecurity to ensure better pregnancy outcomes. Similarly, stakeholders pointed out that to promote health equity, the way in which medical institutions utilize and allocate resources to a community must be based on need. Stakeholders held that in Cleveland and Cuyahoga County, where the largest percentage of families that experience infant mortality, prematurity, and early pregnancy loss are African American, new resources should be allocated to address this disparity.

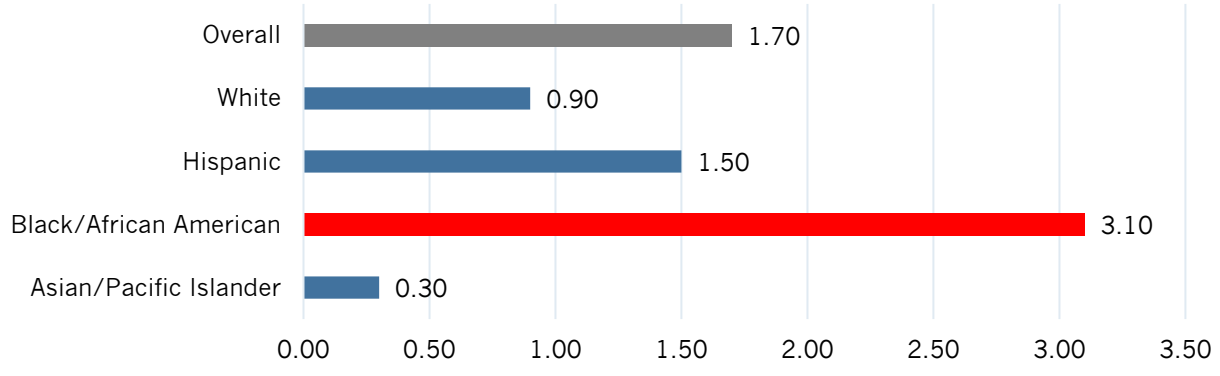
Participants shared concerns that children across the service area experienced learning loss during the pandemic as classrooms went remote and many parents were often unable to provide time away from work to attend to their child's educational needs. Parents identifying as Asian American or Pacific Islander (AAPI) reportedly opted to continue with remote options even after in-person learning resumed for fear of anti-Asian sentiment being expressed to their children by classmates. Related to learning loss and pandemic-associated isolation, children have worsening mental and behavioral health issues. Isolation also kept parents from seeking primary care services for their children, including immunizations and well child visits. Finally, key stakeholders expressed that disparities in health outcomes were exacerbated among children in households with low income.

Secondary Data

Among all health topics, Maternal, Fetal and Infant Health ranked eighth with a score of 1.56. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and can be found in Appendix C and are discussed below. In addition, the appendices also contain a description of methodology (Appendix A) and a full list of indicators with data scoring categorized within this topic area (Appendix C).

Child Food Insecurity Rate, Babies with Low Birth Weight, and Babies with Very Low Birth Weight are some of the worst-performing indicators in Cuyahoga County. When looking at Babies with Low and Very Low Birth Weights, Cuyahoga County ranks in the worst 25% of Ohio counties. Black/African American residents in Cuyahoga County see a higher rate of Babies with Very Low Birth Weight, as shown in Figure 31.

Figure 31. Babies with Very Low Birth Weight by Race/Ethnicity in Cuyahoga County



Source: Ohio Department of Health, Vital Statistics, 2020

Prioritized Health Topic #5: Socioeconomic Issues

Prevention and Safety

Secondary Data Score: 2.21

Key Themes from Community Input

- Food insecurity increased with unemployment during the pandemic
- Generational poverty, poor housing and lack of resources available to create healthy conditions for people to live, work, and play in
- Gun violence was a top community concern
- People without safe and affordable housing are an underserved population

Warning Indicators

- Adults with Current Asthma
- Age-Adjusted Death Rate due to Falls
- Age-Adjusted Death Rate due to Unintentional Injuries
- Age-Adjusted Death Rate due to Unintentional Poisonings
- Annual Ozone Air Quality
- Asthma: Medicare Population
- Blood Lead Levels in Children (>=10 micrograms per deciliter)
- Blood Lead Levels in Children (>=5 micrograms per deciliter)
- Children with Low Access to a Grocery Store
- Death Rate due to Drug Poisoning
- Farmers Market Density
- Fast Food Restaurant Density
- Food Environment Index
- Houses Built Prior to 1950
- People 65+ with Low Access to a Grocery Store
- Physical Environment Ranking
- Severe Housing Problems
- SNAP Certified Stores
- WIC Certified Stores

Primary Data: Key Stakeholder Interviews and Community Engagement Session

During the Stephanie Tubbs Jones Health Center Community Engagement Session education, poor housing, the built environment and poverty were top of mind. Participants noted that community members, particularly Black/African American men, lacked professional development opportunities in trade to boost employment prospects and provide a living wage. They further suggested that home ownership and other long-term housing prospects were in short supply for community members. Landowner responsibilities to provide upkeep on homes often go unfulfilled, bringing down overall home values and keeping potential new residents away. Additionally, green spaces to enhance the built environment and provide recreational areas to support positive youth programming in the community are limited. Finally, underemployment, low wages, inflation impact and a lack of personal capital to invest in home ownership, maintenance and improvement were all reported challenges in the community.

Key stakeholders couched discussions around specific health needs in the context of intergenerational experiences of poverty, poor housing conditions, and historical redlining. Generally, there is a lack of resources individually and as a community to create healthy conditions for people to live, work and play. Finally, concerns were shared about transgender patients experiencing higher rates of victimization and murder.

> The biggest disparities that we are working on right now are infant mortality, lead poisoning, community violence and behavioral health. There is inequity imbedded into our economic and educational system that so greatly impact health outcomes.
>
> - Key Stakeholder

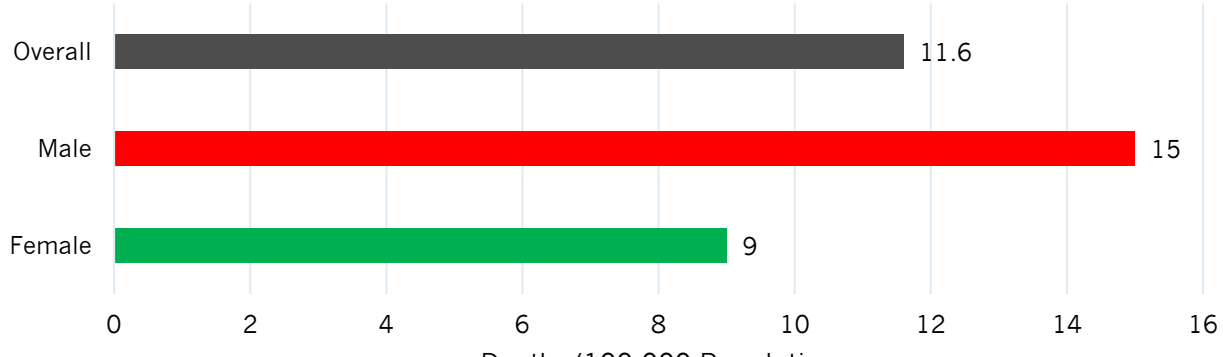
Secondary Data

Prevention & Safety ranked first among all health topics with a score of 2.21. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and can be found in Appendix C and are discussed below. In addition, the appendices also contain a description of methodology (Appendix A) and a full list of indicators with data scoring categorized within this topic area (Appendix C).

Death Rate due to Drug Poisoning ranked highest in this topic area for Cuyahoga County with a death rate of 42.6 deaths per 100,000 population, compared to Ohio's rate of 38.1 and the U.S. rate of 21. This indicator is also increasing significantly in Cuyahoga County.

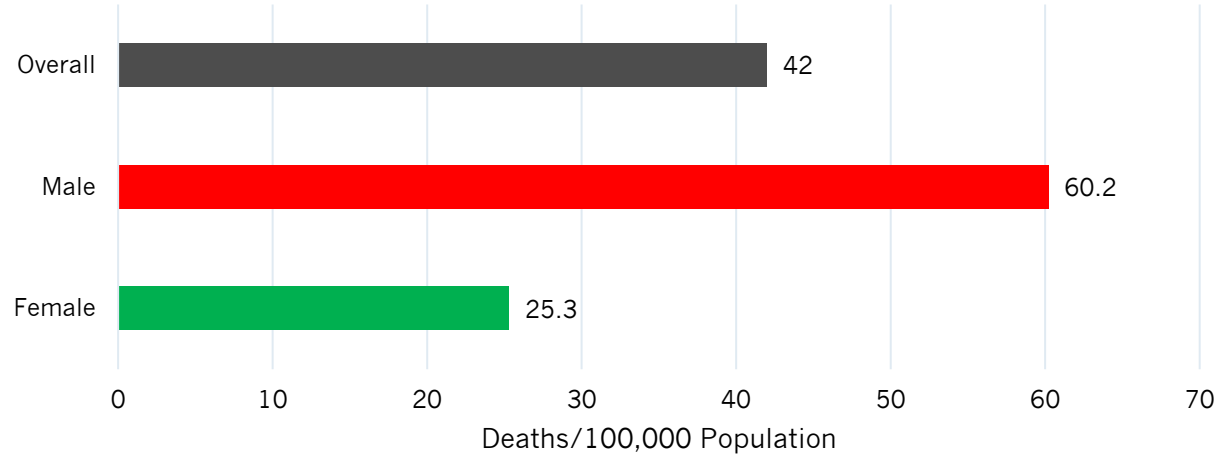
Additionally, disparities were identified in this topic area for Cuyahoga County and are shown below. In Cuyahoga County, disparities exist for males in the following indicators: Age-Adjusted Death Rate due to Falls, Age-Adjusted Death Rate due to Unintentional Poisonings, and Age-Adjusted Death Rate due to Unintentional Injuries as seen in Figures 32, 33 and 34.

Figure 32. Age-Adjusted Death Rate due to Falls by Gender



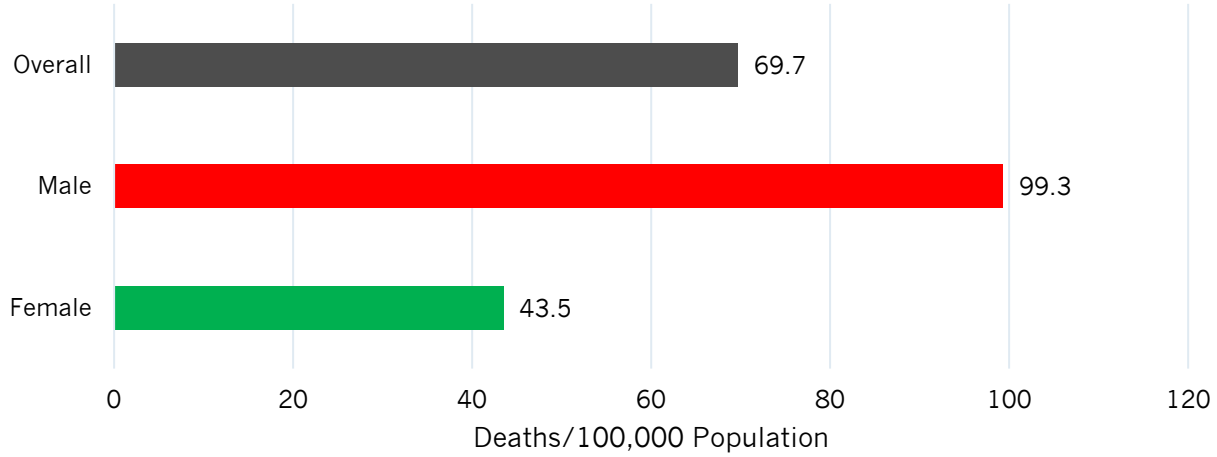
Source: Centers for Disease Control and Prevention, 2017-2019

Figure 33. Age-Adjusted Death Rate due to Unintentional Poisonings by Gender



Source: Centers for Disease Control and Prevention, 2017-2019

Figure 34. Age-Adjusted Death Rate due to Unintentional Injuries by Gender



Source: Centers for Disease Control and Prevention, 2017-2019

2022 Cleveland Clinic Main Campus CHNA Alignment

The final prioritized health needs from this 2022 Cleveland Clinic Main Campus CHNA are in alignment with some of the top priorities and factors influencing health outcomes from the 2019 Ohio State Health Assessment/State Health Improvement Plan. They continue alignment with the 2019 Cleveland Clinic Main Campus CHNA priority areas. The check mark icon in Figure 35 indicates areas of alignment.

Figure 35. Cleveland Clinic Main Campus CHNA Alignment

2019 Ohio SHA/SHIP	2019 Cleveland Clinic Main Campus CHNA	2022 Cleveland Clinic Main Campus CHNA
Top Health Priorities: ☑ • Mental Health & Addiction ☑ • Chronic Disease ☑ • Maternal and Infant Health Top Priority Factors Influencing Health Outcomes: ☑ • Community Conditions ☑ • Health Behaviors ☑ • Access to Care	Priority Health Areas: ☑ • Access to Affordable Healthcare ☑ • Addiction and Mental Health ☑ • Chronic Disease Prevention and Management ☑ • Infant Mortality ☑ • Socioeconomic Concerns • Medical Research and Health Professions Education	Prioritized Health Needs: ☑ • Access to Healthcare ☑ • Behavioral health (Mental health and Substance Use Disorder) ☑ • Chronic disease prevention and management ☑ • Maternal and child health ☑ • Socioeconomic issues

Cleveland Clinic Children's Community Health Needs Assessment

Introduction

Cleveland Clinic Children's offers three facilities dedicated to the medical, surgical and rehabilitative care of infants, children and adolescents. Our Inpatient Hospital and Outpatient Center are both located at our main campus in Cleveland, OH. We also offer inpatient and outpatient care at many of our regional hospitals and family health centers throughout Northeast Ohio.

We have more than 300 pediatric specialists who are leaders in research for cardiac care, neurological conditions, digestive diseases and other conditions. Cleveland Clinic Children's is consistently rated among the "Best Children's Hospitals" by U.S. News & World Report."

Demographics of the Cleveland Clinic Children's Community

The demographics of a community significantly impact its health profile.[28] Different racial, ethnic, age, and socioeconomic groups may have unique needs and require varied approaches to health improvement efforts. The following section explores the demographic profile of the community residing in the Cleveland Clinic Children's Community Definition.

Geography and Data Sources

Data are presented in this section at the geographic level of the Cleveland Clinic Children's Hospital Community Definition. Comparisons to the county, state, and national value are also provided when available. All demographic estimates are sourced from Claritas Pop-Facts® (2022 population estimates) and American Community Survey[29] one-year (2019) or five-year (2015-2019) estimates unless otherwise indicated.

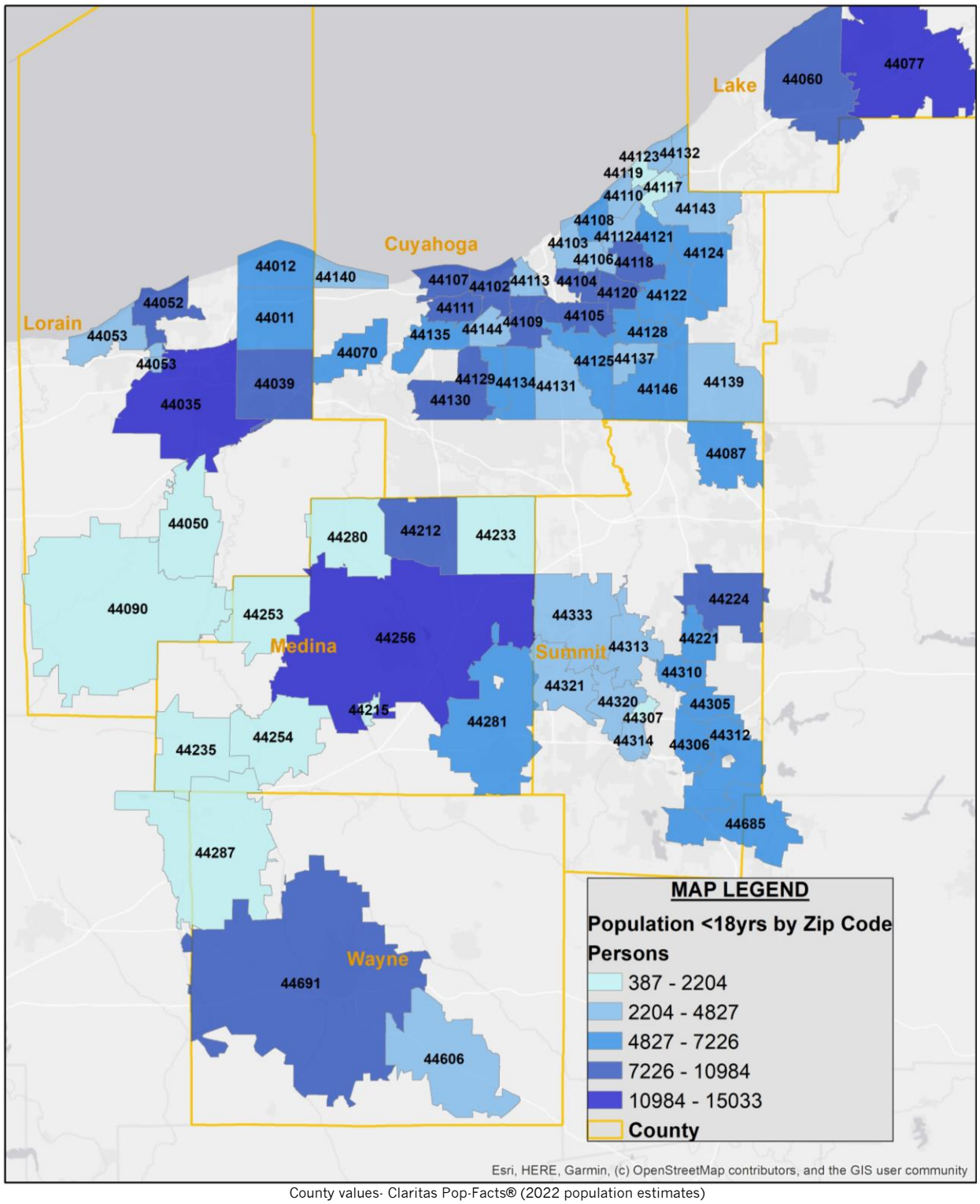
Population

According to the 2022 Claritas Pop-Facts® population estimates, the Cleveland Clinic Children's Community has an estimated population of 394,360 persons aged less than 18 years. Figure 36 shows the population less than 18 years for each zip code, with the darkest blue representing the zip codes with the largest population. Appendix C provides the actual population estimates for each zip code. The most populated zip code area within the Cleveland Clinic Children's Community is zip code 44256 (Medina) with a population aged less than 18 years of 15,033 person.

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

[29]

Figure 36: Population <18 years by Zip Code

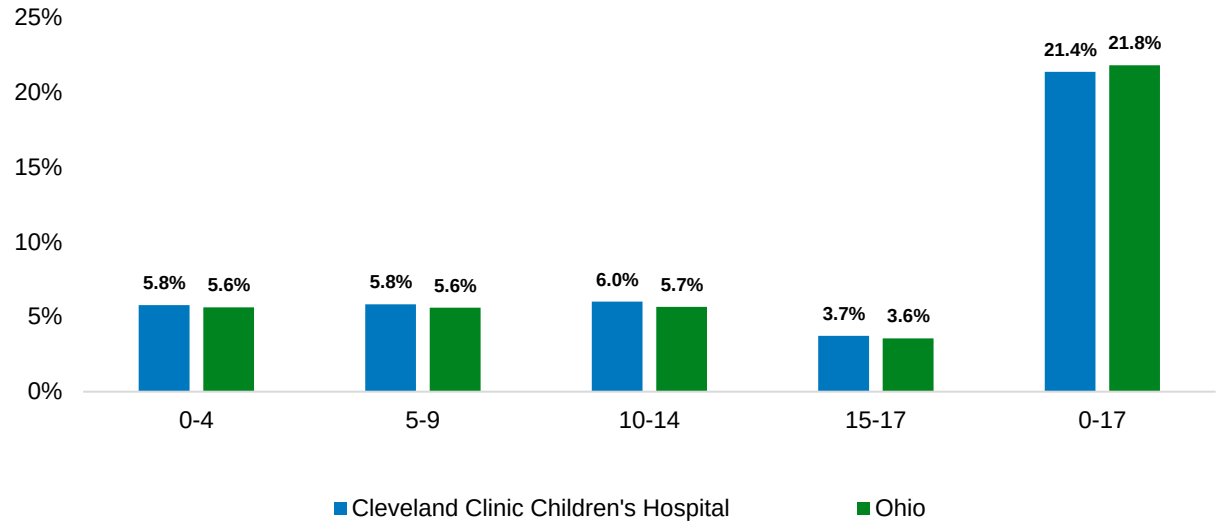


County values- Claritas Pop-Facts® (2022 population estimates)

Age

Children (0-17) comprised 21.4% of the total population in the Cleveland Clinic Children's Community which is slightly less than the state of Ohio children's population (21.8%). Figure 37 shows further breakdown of age categories.

Figure 37: Population by Age: Hospital and State Comparisons

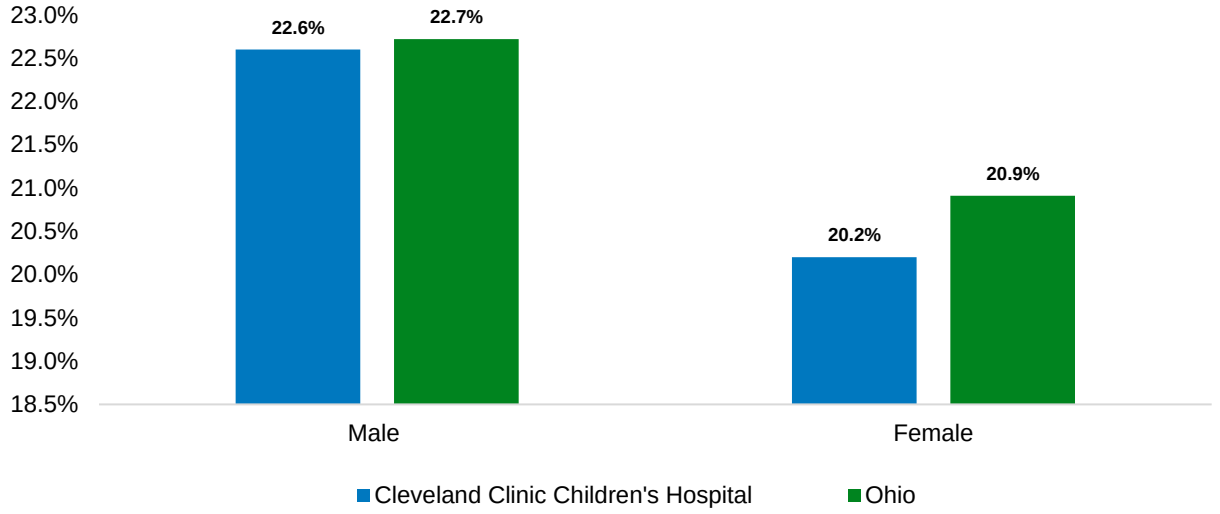


County and state values- Claritas Pop-Facts® (2022 population estimates)

Sex

Figure 38 shows the total population <18 years of the Cleveland Clinic Children's Community by sex. Males aged <18 years comprise 22.6% of the population in the Cleveland Clinic Children's ommunity, which is slightly less than the Ohio value (22.7%). Whereas females aged <18 years comprise 20.2% of the population in the Cleveland Clinic Children's Community which is slightly less than Ohio value (20.9%).

Figure 38: Population <18 years by Sex: Hospital and State Comparisons



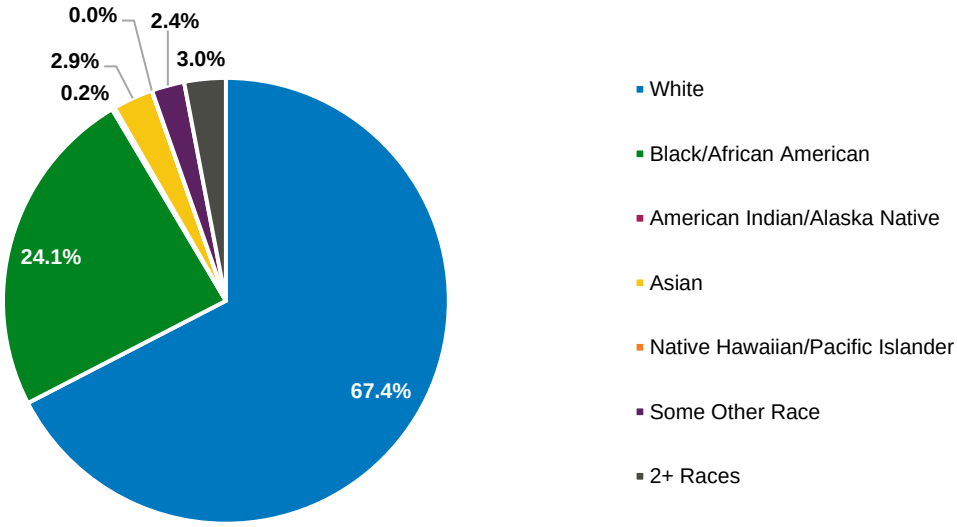
County and state values- Claritas Pop-Facts® (2022 population estimates) U.S. values taken from American Community Survey five-year (2015-2019) estimates

Race and Ethnicity

Race and ethnicity contribute to the opportunities individuals and communities have to be healthy. The racial and ethnic composition of a population is also important in planning for future community needs, particularly for schools, businesses, community centers, healthcare, and childcare.

The racial makeup of Cleveland Clinic Children's area shows 67.4% of the population identifying as White, as indicated in Figure 39. The percentage of Black/African American community members is the second largest of all races in the Cleveland Clinic Children's Community at 24.1%.

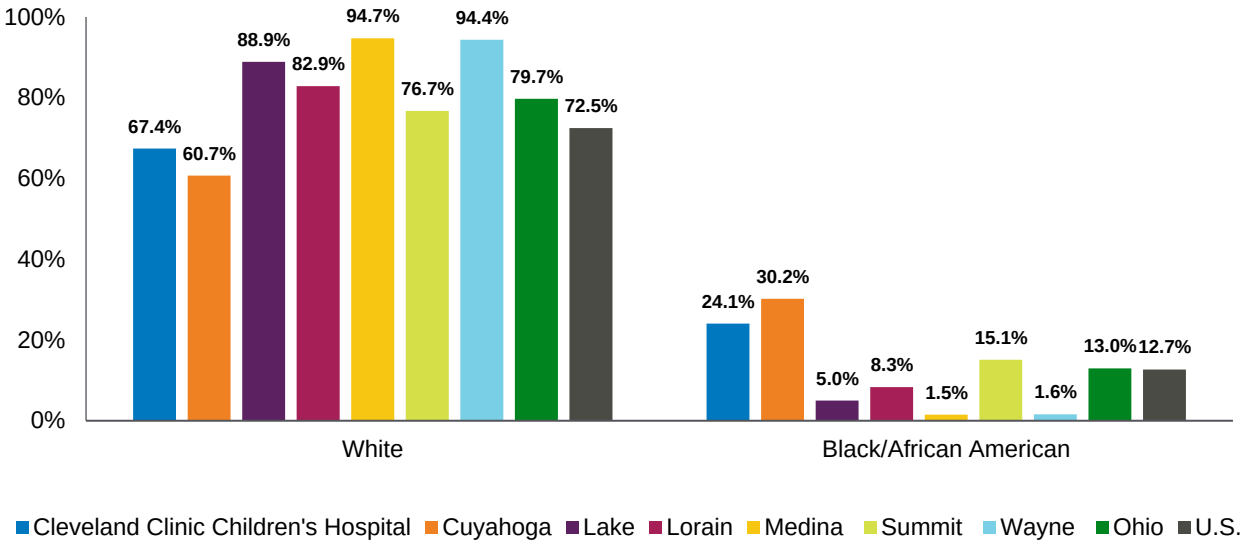
Figure 39: Population by Race: The Cleveland Clinic Children's Community



County values- Claritas Pop-Facts® (2022 population estimates)

Those community members identifying as White represent a smaller percentage of the total population in the Cleveland Clinic Children's Community (67.4%) when compared to Ohio (79.7%) and the U.S. (72.5%), while Black/African American community members represent a higher percentage of population in the Cleveland Clinic Children's Community (24.1%) when compared to Ohio (13.0%) and the U.S. (12.7%). Cuyahoga County has the largest percentage of community members identifying as Black/African American (30.2%) included in the Cleveland Clinic Children's Community Definition. (Figure 40)

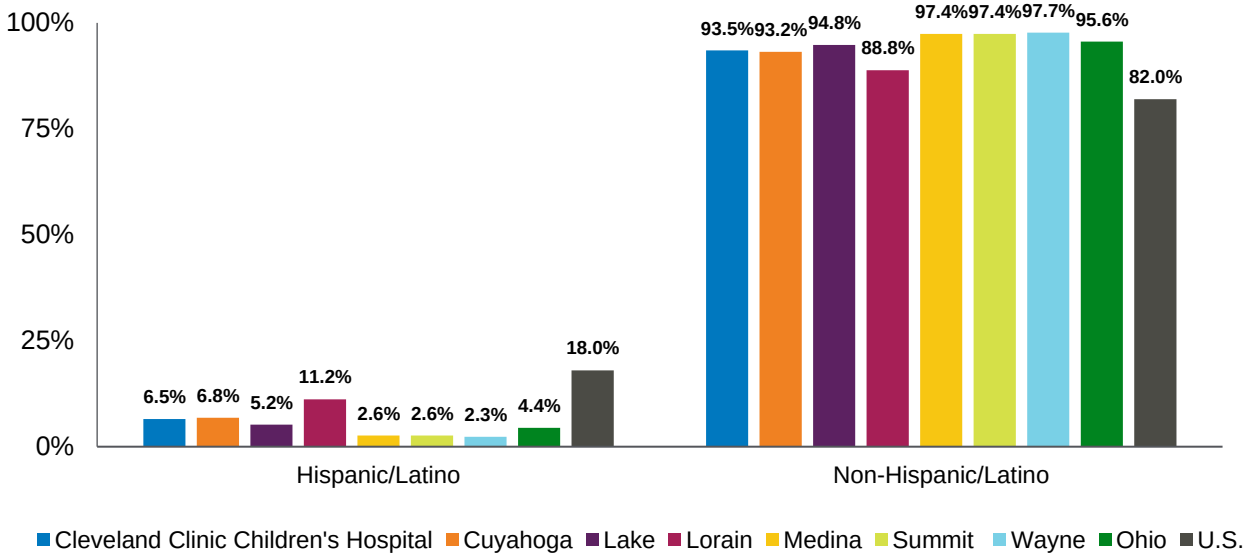
Figure 40: Population by Race: Hospital, County, State, and U.S. Comparisons



County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2015-2019) estimates

As shown in Figure 41, 6.5% of the population in the Cleveland Clinic Children's Community identify as Hispanic/Latino, this is a larger percentage of the population when compared to Ohio (4.4%) but smaller when compared to the U.S. (18.0%). Lorain County has the largest percentage of community members who identify as Hispanic/Latino (11.2%).

Figure 41: Population by Ethnicity: Hospital, County, State, and U.S. Comparisons



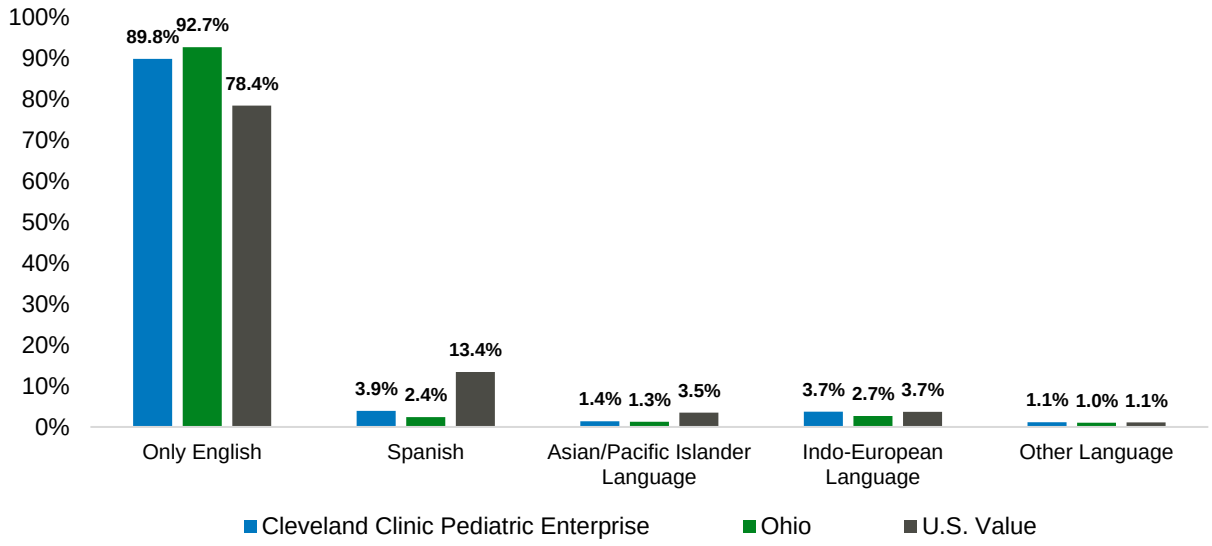
County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2015-2019) estimates

Language and Immigration

Understanding countries of origin and language spoken at home can help inform the cultural and linguistic context for the health and public health system.

In the Cleveland Clinic Children's Community, 89.8% of the population age five and older speak only English at home, which is lower than the state value of 92.7% but higher than the national value of 78.4% (Figure 42). This data indicates that 3.9% of the population in the Cleveland Clinic Children's Community speak Spanish, 1.4% speak an Asian/Pacific Islander language, 3.7% speak an Indo-European Language, and 1.1% speak Other Languages at home.

Figure 42: Population 5+ by Language Spoken at Home: Hospital, State and U.S. Comparisons



County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2015-2019) estimates

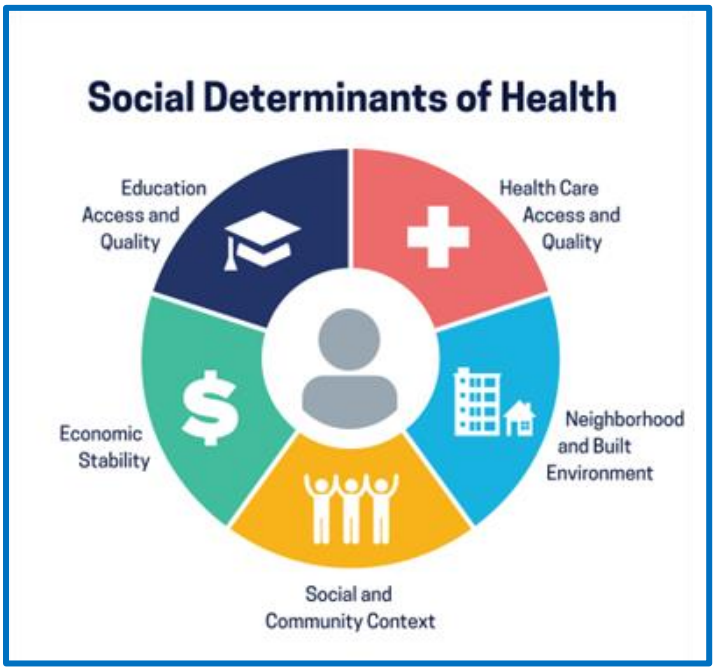
Highlighted Demographics: Children's Social and Economic Determinants of Health

This section explores the economic, environmental, and social determinants of health impacting the Cleveland Clinic Children's Community. The social determinants 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[30]. The social determinants of health (SDOH) can be grouped into five domains. Figure 43 shows the Healthy People 2030 Social Determinants of Health domains[31].

[30] World Health Organization. Social Determinants of Health. https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1

[31] Healthy People 2030, 2022. Social Determinants of Health Domains. https://health.gov/healthypeople/priority-areas/social-determinants-health

Figure 43: Healthy People 2030 Social Determinants of Health Domains



Geography and Data Sources

Data in this section are presented at various geographic levels (zip code and/or county) and age groups depending on data availability. When available, comparisons to county, state, and/or national values are provided. It should be noted that county level data can sometimes mask what could be going on 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 disparities.
All demographic estimates are sourced from Claritas Pop-Facts® (2022 population estimates) and American Community Survey one-year (2019) or five-year (2015-2019) estimates unless otherwise indicated.

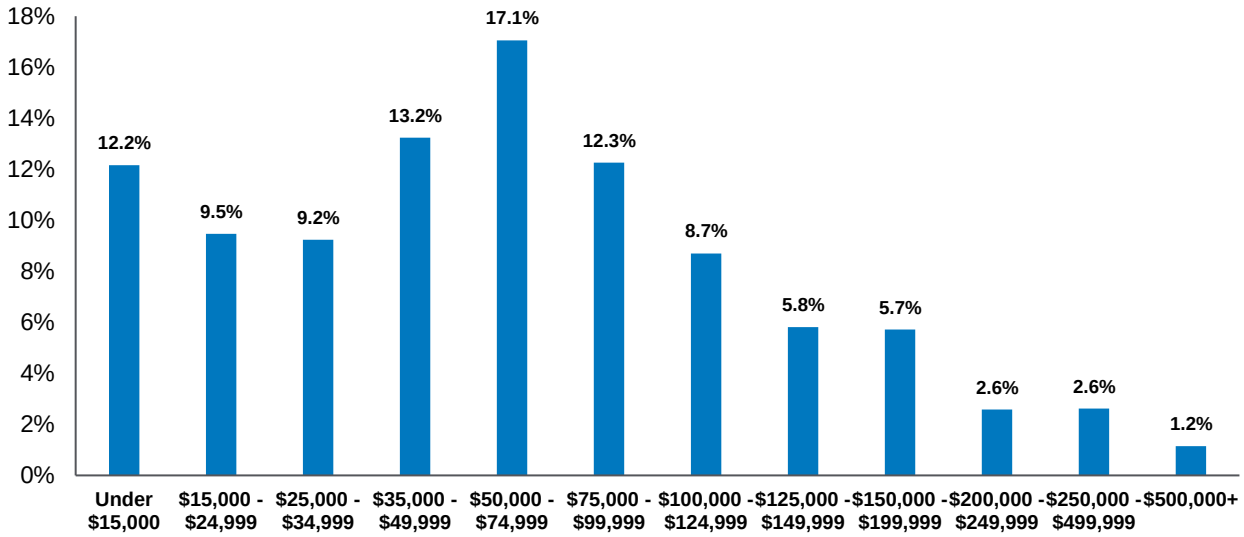
Income

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.[32]

Figure 44 provides a breakdown of households by income in the Cleveland Clinic Children's Community Definition. A household income of $50,000 - $74,999 is shared by the largest percentage of households in the Cleveland Clinic Children's Community (17.1%). Households with an income of less than $15,000 make up 12.2% of households in the Cleveland Clinic Children's Community.

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

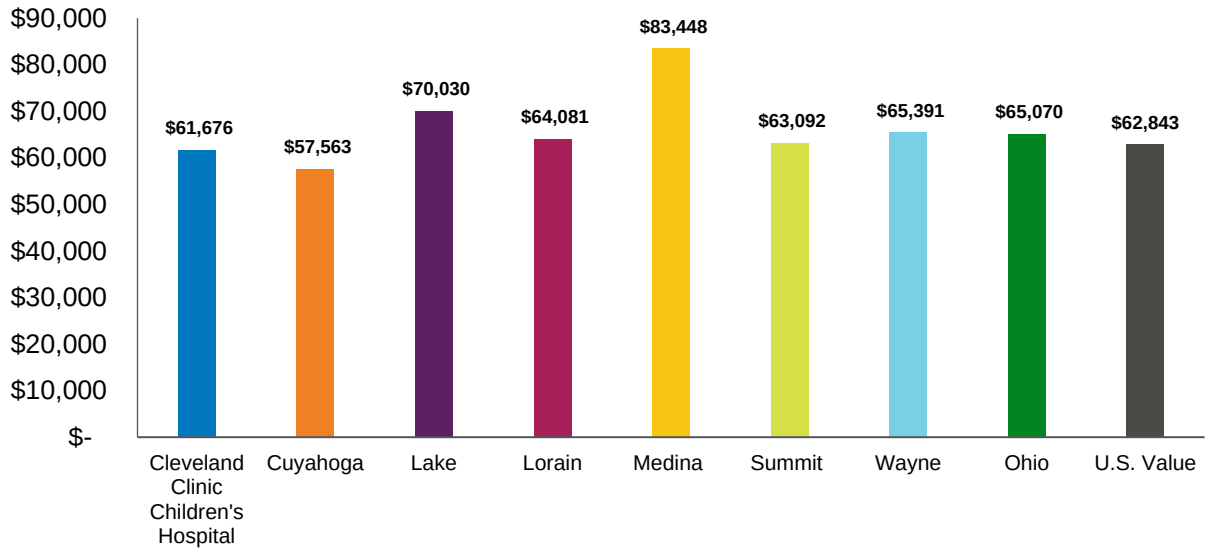
Figure 44: Households by Income: The Cleveland Clinic Children's Community



County values- Claritas Pop-Facts® (2022 population estimates)

The median household income for the Cleveland Clinic Children's Community is $61,676, which is lower than the state value of $65,070 and national value of $62,843 (Figure 45).

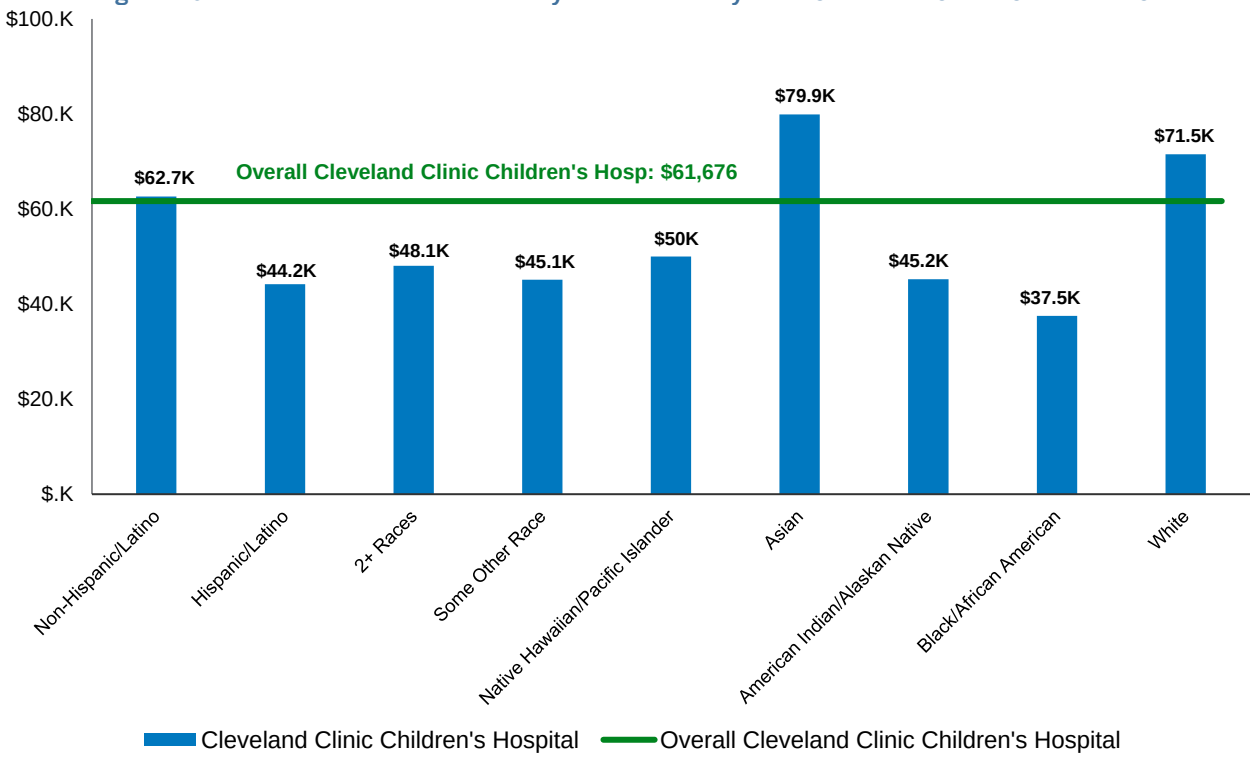
Figure 45: Household Income by: Hospital, County, State, and U.S. Comparisons



County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2015-2019) estimates

Figure 46 shows the median household income by race and ethnicity. Three racial/ethnic groups – White, Asian, and Non-Hispanic/Latino– have median household incomes above the overall value. All other races have incomes below the overall value, with the Black/African American population having the lowest median household income at $37,527.

Figure 46: Median Household Income by Race/Ethnicity: The Cleveland Clinic Children's Community



County values- Claritas Pop-Facts® (2022 population estimates)

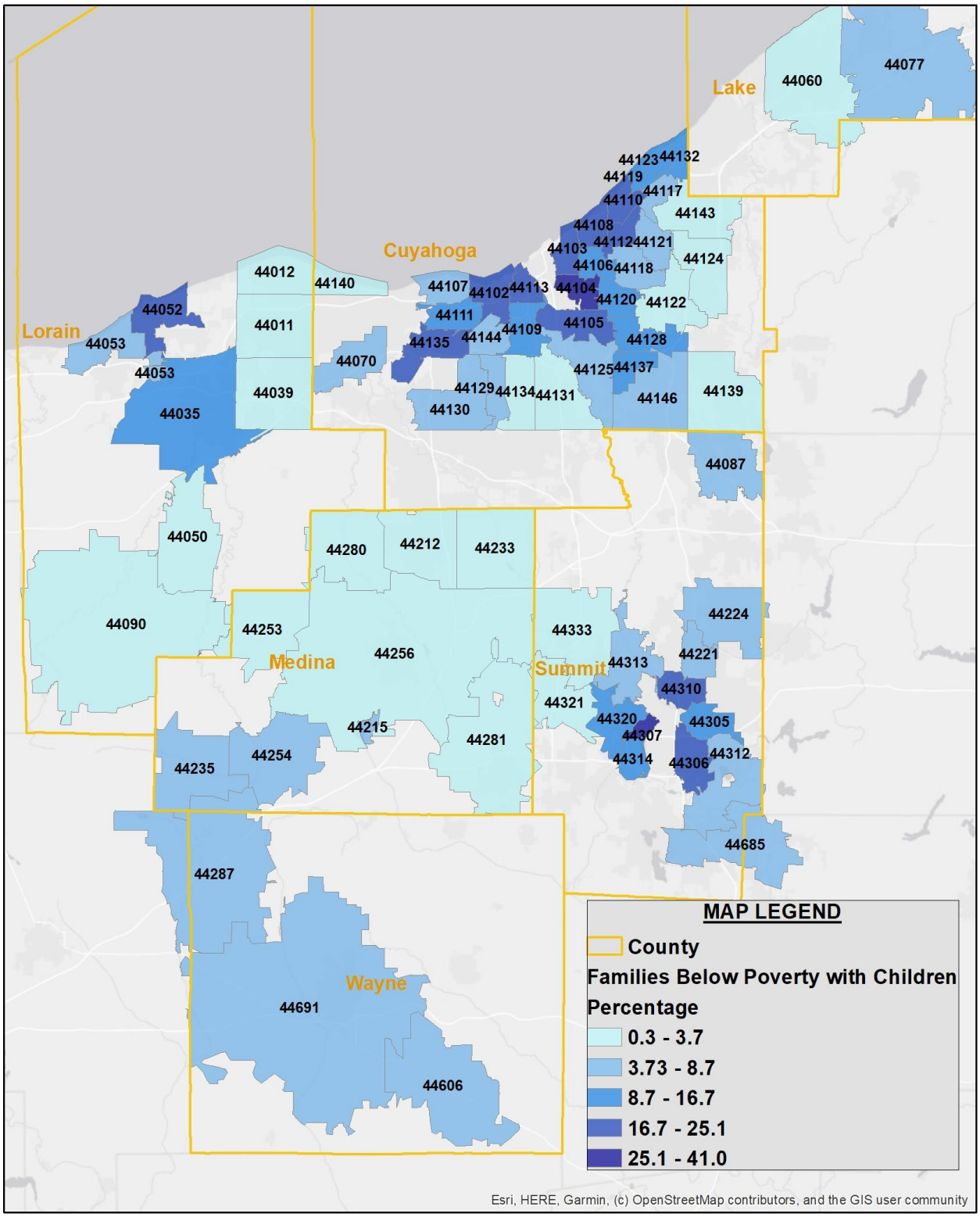
Poverty

Federal poverty thresholds are set every year by the Census Bureau and vary by size of family and ages of family members. People living in poverty are less likely to have access to healthcare, healthy food, stable housing, and opportunities for physical activity. These disparities mean people living in poverty are more likely to experience poorer health outcomes and premature death from preventable diseases.[33]

Figure 47 shows the percentage of families with children living below the poverty level by zip code. The darker blue colors represent a higher percentage of families living below the poverty level, with zip codes 44104 (Cuyahoga) and 44307 (Summit) having the highest percentages at 41.0% and 33.7%, respectively. Overall, 8.6% of families with children in the Cleveland Clinic Children's Community live below the poverty level, which is higher than the state value of 7.3% but lower than the national value of 9.5%. The percentage of families living below the poverty level for each zip code in the Cleveland Clinic Children's Community is provided in Appendix C

[33] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/browse-objectives/economic-stability/reduce-proportion-people-living-poverty-sdoh-01

Figure 47: Families with Children Living Below Poverty



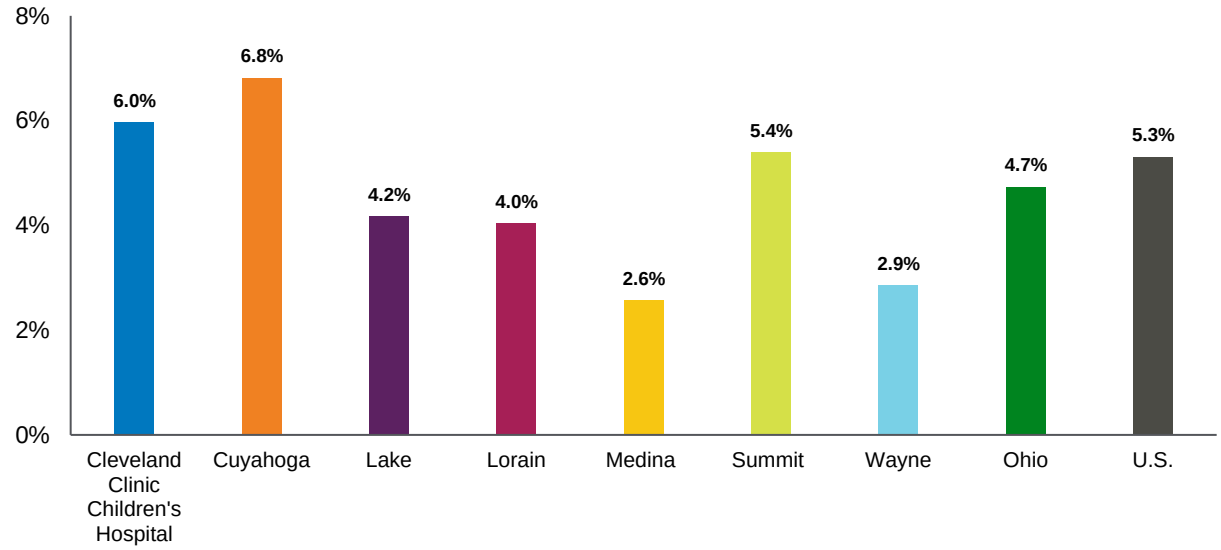
County values- Claritas Pop-Facts® (2022 population estimates)

Employment

A community's employment rate is a key indicator of the local economy. An individual's type and level of employment impacts access to healthcare, work environment, health behaviors, and health outcomes. Stable employment can help provide benefits and conditions for maintaining good health. In contrast, poor or unstable work and working conditions are linked to poor physical and mental health outcomes.[34]

Unemployment and underemployment can limit access to health insurance coverage and preventive care services. Underemployment is described as involuntary part-time employment, poverty-wage employment, and insecure employment.[15] Type of employment and working conditions can also have significant impacts on health. Work-related stress, injury, and exposure to harmful chemicals are examples of ways employment can lead to poorer health.[15] Figure 48 shows the population aged 16 and over who are unemployed. The unemployment rate for the Cleveland Clinic Children's Community is 6.0%, which is higher than the state value of 4.7% and the national value of 5.3%.

Figure 48: Population 16+ Unemployed: Hospital, County, State, and U.S. Comparison



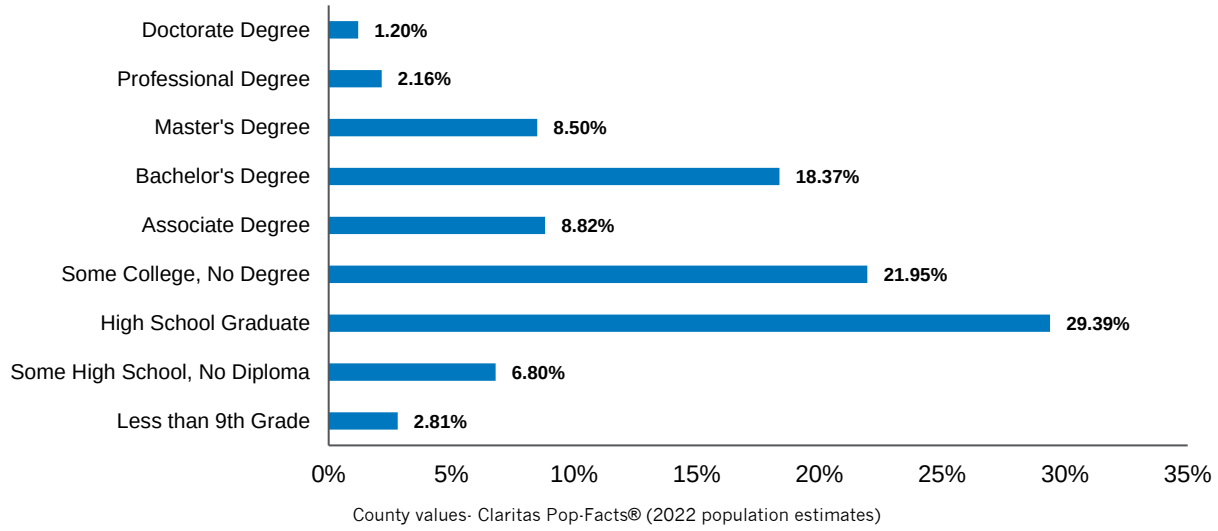
County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2015-2019) estimates

Education

Education is an important indicator for 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. People with higher levels of education are likely to live longer, to experience better health outcomes, and practice health-promoting behaviors.[35]
Figure 49 shows the percentage of the population 25 years or older by educational attainment.

[34] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/social-determinants-health/literature-summaries/employment
[35] Robert Wood Johnson Foundation, Education and Health. https://www.rwjf.org/en/library/research/2011/05/education-matters-for-health.html

Figure 49: Population 25+ by Education Attainment: The Cleveland Clinic Children's Community

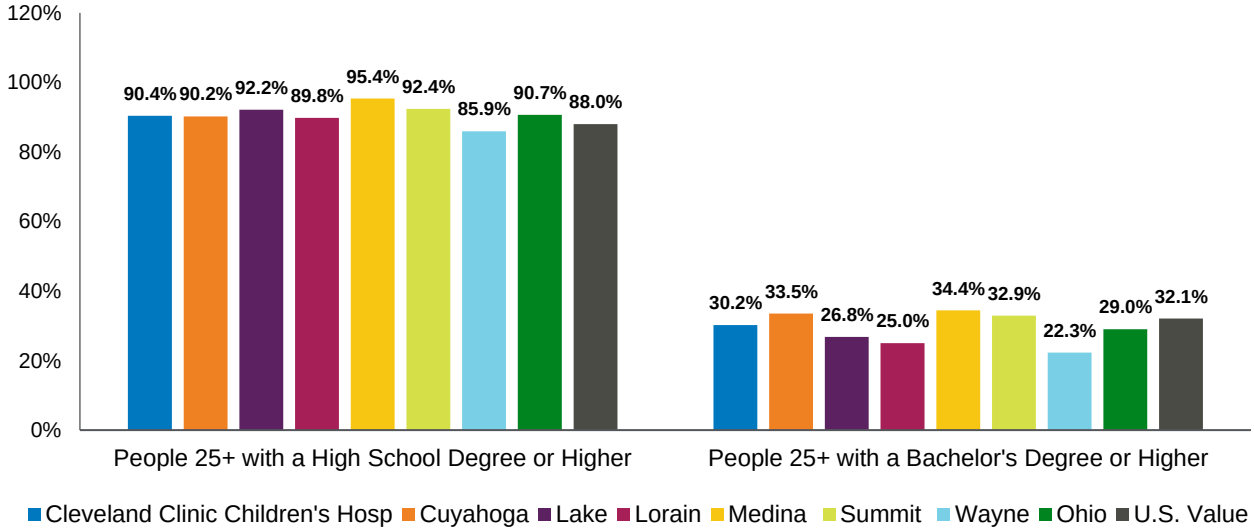


County values- Claritas Pop-Facts® (2022 population estimates)

Another indicator related to education is on-time high school graduation. A high school diploma is a requirement for many employment opportunities and for higher education. Not graduating high school is linked to a variety of negative health impacts, including limited employment prospects, low wages, and poverty.[36]

Figure 50 shows that the Cleveland Clinic Children's Community has a slightly smaller percentage of residents with a High School degree or higher (90.4%) when compared to Ohio value (90.7%) but higher than the U.S. value (88.0%). The community has a higher percentage of residents with a Bachelor's degree or higher (30.2%) when compared to Ohio value (29.0%) but a lesser percentage than the U.S.(32.1%).

Figure 50: Population 25+ by Education Attainment: Hospital, County, State, and U.S. Comparisons



County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2015-2019) estimates

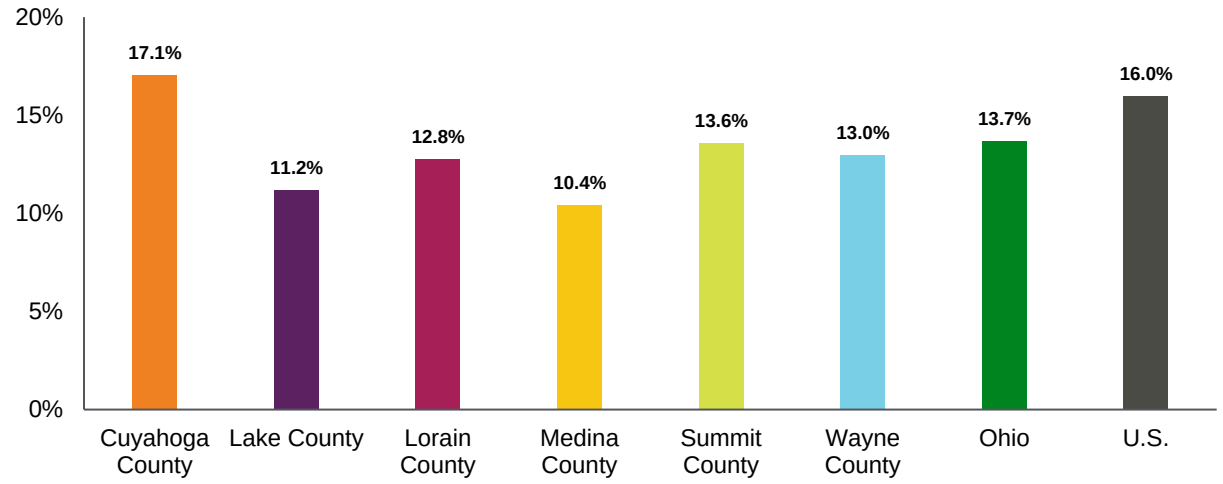
[36] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/social-determinants-health/literature-summaries/high-school-graduation

Housing

Safe, stable, and affordable housing provides a critical foundation for health and wellbeing. Exposure to health hazards and toxins in the home can cause significant damage to an individual or family's health.[37]

Figure 51 shows the percentage of houses with severe housing problems. This indicator measures the percentage of households with at least one of the following problems: overcrowding, high housing costs, lack of kitchen, or lack of plumbing facilities. Cuyahoga County has the highest percentage of houses with severe housing problems.

Figure 51: Severe Housing Problems: County, State, and U.S. Comparisons



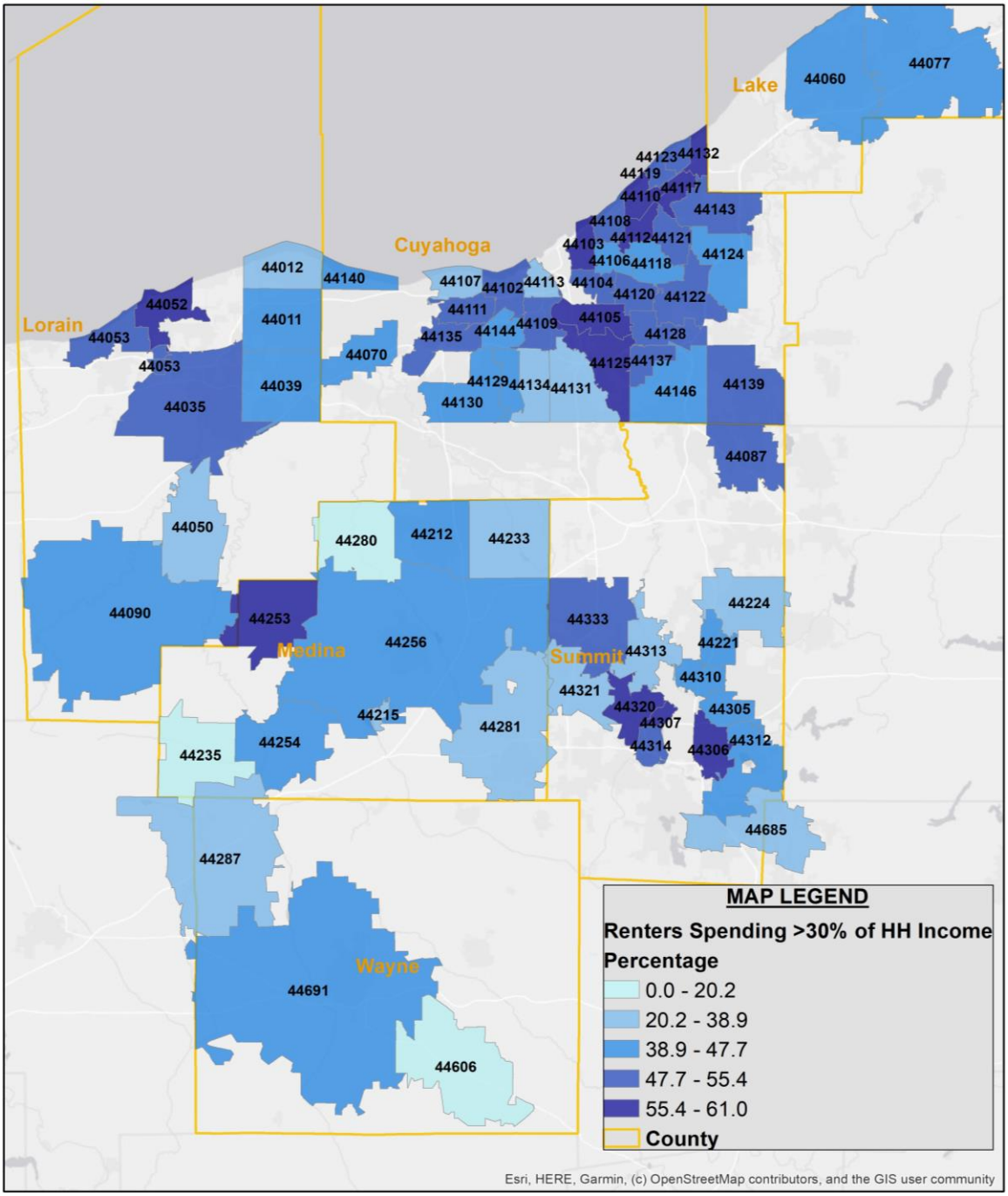
County, state values, and U.S. values taken from County Health Rankings (2013-2017)

When families must spend a large portion of their income on housing, they may not have enough money to pay for things like healthy foods or healthcare. This is linked to increased stress, mental health problems, and an increased risk of disease.[38] Figure 52 shows the percentage of renters who are spending 30% or more of their household income on rent.

[37] County Health Rankings, Housing and Transit. https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model/health-factors/physical-environment/housing-and-transit

[38] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/browse-objectives/housing-and-homes/reduce-proportion-families-spend-more-30-percent-income-housing-sdoh-04

Figure 52: Renters Spending 30% Or More Of Household Income on Rent



County values· American Community Survey five-year (2015-2019) estimates

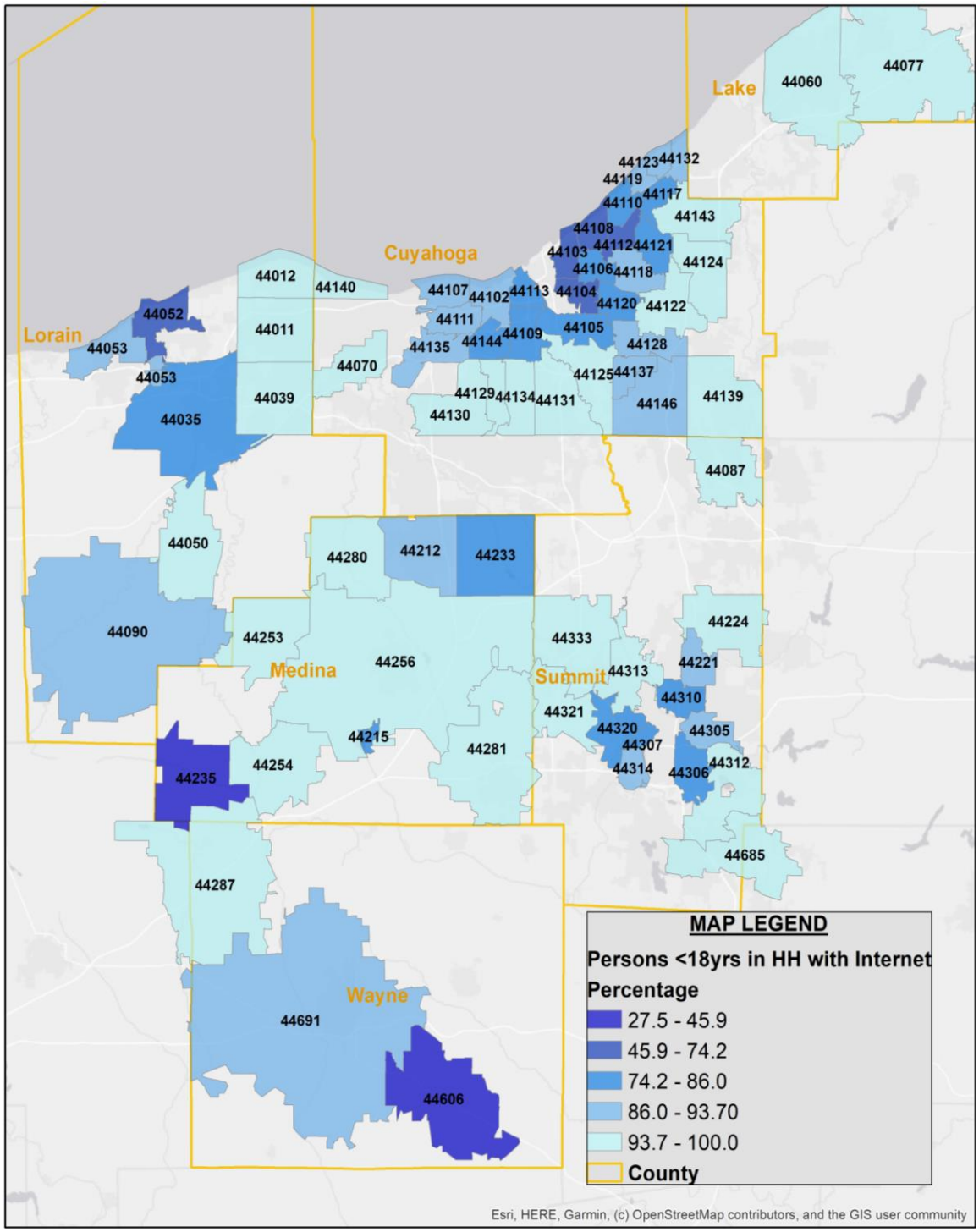
Neighborhood and Built Environment

Internet access is essential for basic healthcare access, including making appointments with providers, getting test results, and accessing medical records. Access to the internet is also increasingly essential for obtaining home-based telemedicine services.[39]

[39] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/browse-objectives/neighborhood-and-built-environment/increase-proportion-adults-broadband-internet-hchit-05

Internet access may also help individuals seek employment opportunities, conduct remote work, and participate in online educational activities.[20] Figure 53 shows the percentage of Persons in Households that have an internet subscription and are <18 years. 44606 (Wayne) has the least percentage of households with internet connection, represented by darkest shade of blue on the map.

Figure 53: Persons <18years in Households with an Internet Subscription



County values- American Community Survey five-year (2015-2019) estimates

Highlighted Demographics: Children's Disparities and Health Equity

Identifying disparities by population groups and geography helps to inform and focus priorities and strategies. Understanding disparities also helps us better understand root causes that impact health in a community and inform action towards health equity.

Health Equity

Health equity focuses on the fair distribution of health determinants, outcomes, and resources across communities.[40] National trends have shown that systemic racism, poverty, and gender discrimination have led to poorer health outcomes for groups such as Black/African American, Hispanic/Latino, Indigenous, communities with incomes below the federal poverty level, and LGBTQ+ communities.[41]

Race, Ethnicity, Age & Gender Disparities

Primary and secondary data revealed significant community health disparities by race, ethnicity, gender, and age. It is important to note that the data is presented to show differences and distinctions by population groups. Information and themes captured through key informant interviews and community engagement session discussions have been shared to provide a more comprehensive and nuanced understanding of each community's experiences.

Secondary Data

Community health disparities were assessed in the secondary data using the Index of Disparity[42] analysis, which identifies disparities based on how far each subgroup (by race, ethnicity, or gender) is from the overall county value. For more detailed methodology related to the Index of Disparity, see Appendix A.

Table 2 below identifies secondary data indicators with a statistically significant race or ethnic disparity for the Cleveland Clinic Children's Community, based on the Index of Disparity.

Table 2: Indictors with Significant Race or Ethnic Disparities

Health Indicator	Group(s) Negatively Impacted
4th Grade Students Proficient in Math	American Indian/Alaska Native, Black/African American, Hispanic/Latino, Two or More Races

[40] Klein R, Huang D. Defining and measuring disparities, inequities, and inequalities in the Healthy People initiative. National Center for Health Statistics. Center for Disease Control and Prevention. https://www.cdc.gov/nchs/ppt/nchs2010/41_klein.pdf

[41] Baciu A, Negussie Y, Geller A, et al (2017). Communities in Action: Pathways to Health Equity. Washington (DC): National Academies Press (US); The State of Health Disparities in the United States. Available from: https://www.ncbi.nlm.nih.gov/books/NBK425844/

[42] Pearcy, J. & Keppel, K. (2002). A Summary Measure of Health Disparity. Public Health Reports, 117, 273-280.

Babies with Very Low Birth Weight	Black/African American, Hispanic/Latino, Asian/Pacific Islander
Children Living Below Poverty Level	Black/African American, Hispanic/Latino, Other Race, Two or More Races
People Living Below Poverty Level	American Indian/Alaska Native, Black/African American, Hispanic/Latino, Other Race, Two or More Races, Asian
Families Living Below Poverty Level	American Indian/Alaska Native, Black/African American, Hispanic/Latino, Other Race, Two or More Races, Asian
Young Children Living Below Poverty Level	Black/African American, Hispanic/Latino, Native Hawaiian/Pacific Islander, Other Race, Two or More Races

The Index of Disparity analysis for Cuyahoga, Lake, Lorain, Medina, Summit, and Wayne counties reveals that the Black/African American, Hispanic/Latino, American Indian/Alaskan Native, Two or More Races, Asian, Asian/Pacific Islander, and Other Race group populations are disproportionately impacted by various measures of poverty, which is often associated with poorer health outcomes. These indicators include Families Living Below Poverty Level, Children Living Below Poverty Level, Young Children Living Below Poverty Level, and People Living Below Poverty Level. Furthermore, Black/African American, Asian/Pacific Islander, and Hispanic/Latino populations are disproportionately impacted in Babies with Very Low Birth Weight.

Finally, American Indian/Alaska Native, Black/African American, Hispanic, and Two or More Race groups experience inequities in education, as shown by disparities in 4th Grade Students Proficient in Math(Table 2).

Geographic Disparities

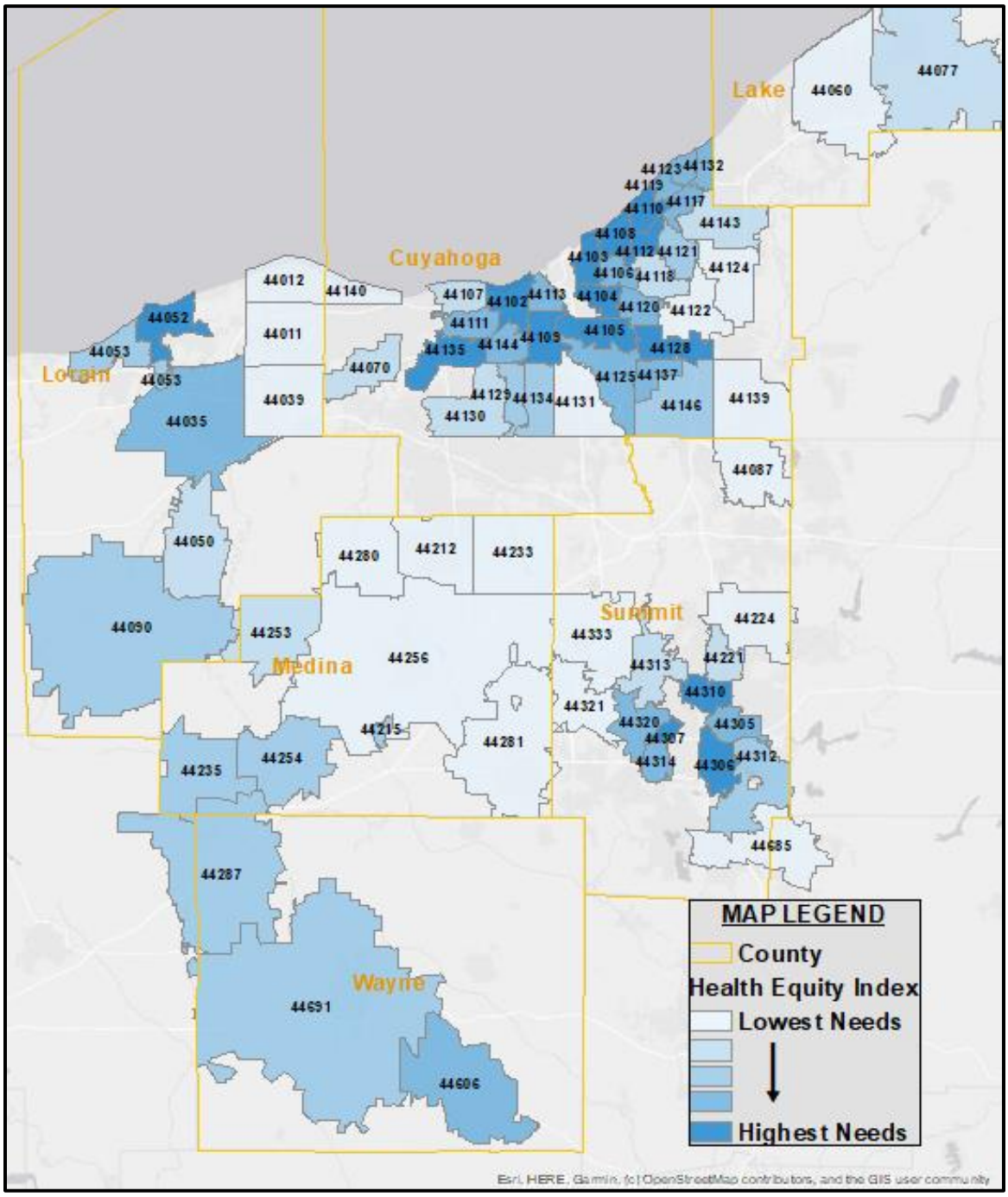
In addition to disparities by race, ethnicity, gender, and age, this assessment also identified specific zip codes/municipalities with differences in outcomes related to health and social determinants of health. Geographic disparities were identified using the Health Equity Index, Food Insecurity Index, and Mental Health Index. These indices have been developed by Conduent Healthy Communities Institute to easily identify areas of high socioeconomic need, food insecurity and poor mental health. For all indices, counties, zip codes, and census tracts with a population over 300 are assigned index values ranging from 0 to 100, with higher values indicating greater need. Understanding where there are communities with higher need is critical to targeting prevention and outreach activities.

Health Equity Index

Conduent's Health Equity Index (HEI) estimates areas of high socioeconomic need, which are correlated with poor health outcomes. Zip codes are ranked based on their index value to identify relative levels of need, as illustrated by the map in Figure 54. The following zip codes in the Cleveland Clinic Children's Community had the highest level of

socioeconomic need (as indicated by the darkest shades of blue): 44052 in Lorain County; 44102, 44135, 44109, 44105, 44104, 44103, 44108, 44112, 44110, and 44128 in Cuyahoga County; 44307, 44306, and 44310 in Summit County. Appendix A provides the index values for each zip code.

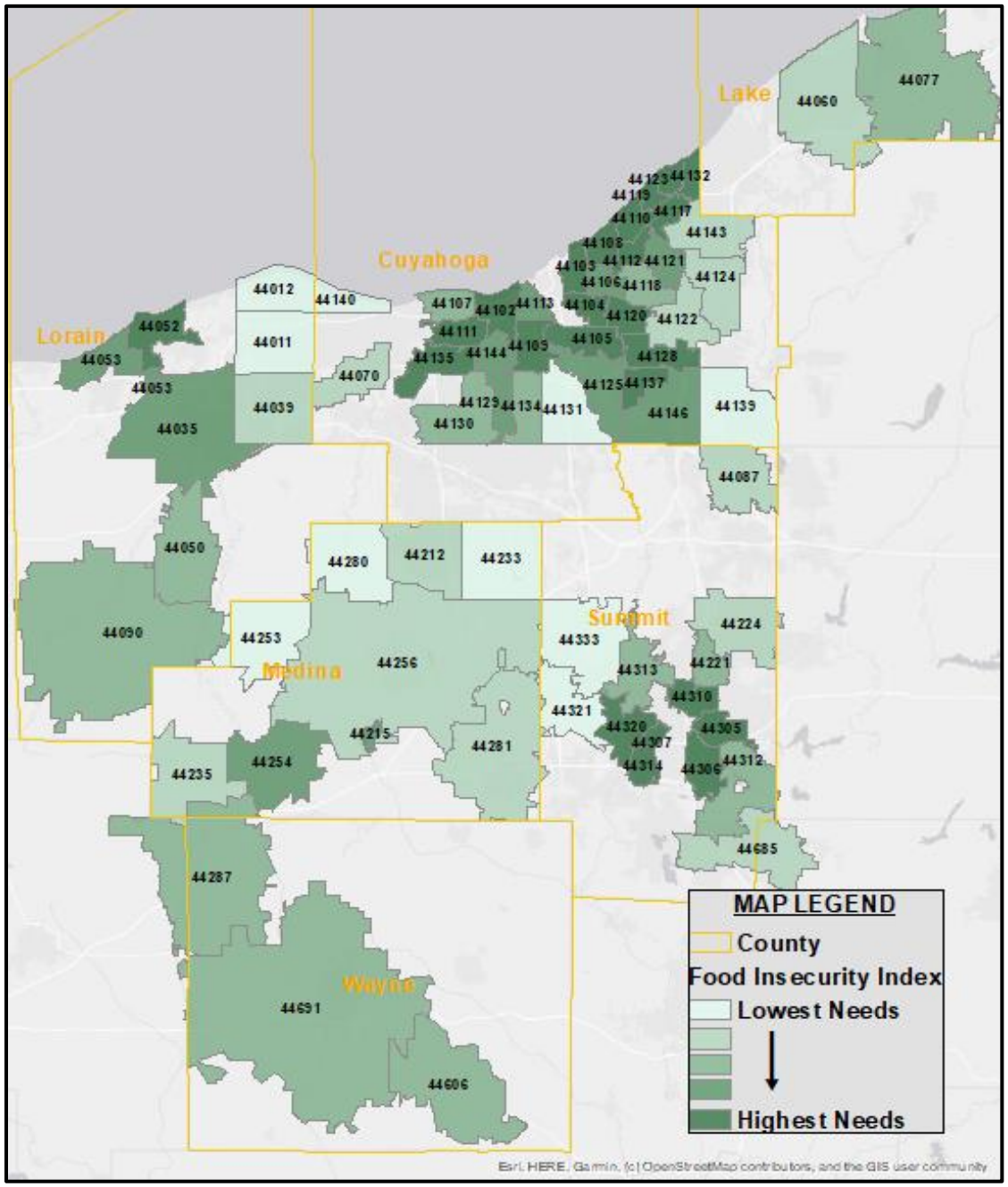
Figure 54: Health Equity Index



Food Insecurity Index

Conduent's Food Insecurity Index (FII) estimates areas of low food accessibility correlated with social and economic hardship. Zip codes are ranked based on their index value to identify relative levels of need, as illustrated by the map in Figure 55. The following zip codes had the highest level of food insecurity (as indicated by the darkest shades of green):44052 in Lorain County; 44135, 44111, 44102, 44109, 44105, 44104, 44120, 44128, 44137, 44103, 44108, 44112, 44110, 44117, 44119, 44123, and 44132 in Cuyahoga County; 44310, 44305, 44306, 44314, 44307, and 44320 in Summit County. Appendix A provides the index values for each zip code.

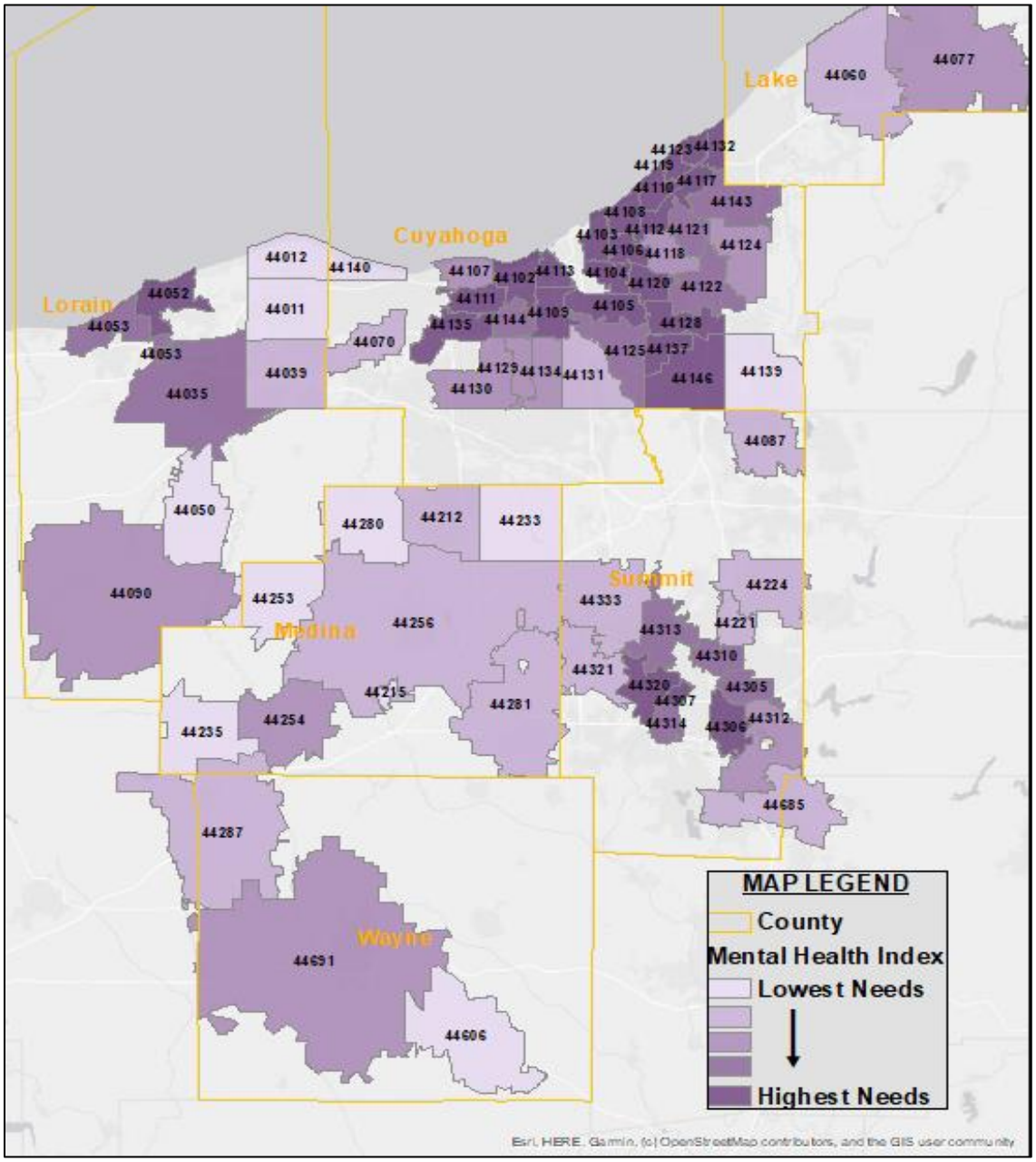
Figure 55: Food Insecurity Index



Mental Health Index

Conduent's Mental Health Index (MHI) is a measure of socioeconomic and health factors correlated with self-reported poor mental health. Zip codes were ranked based on their index value to identify the relative levels of need, as illustrated by the map in Figure 56. The following zip codes are estimated to have the highest need (as indicated by the darkest shades of purple):44052 in Lorain County, 44135, 44111, 44102, 44113, 44109, 44105, 44137, 44146, 44128, 44120, 44104, 44106, 44103, 44108, 44112, 44110, 44119, 44123, 44132, and 44117 in Cuyahoga County; and 44320, 44307, and 44306 in Summit County. Appendix A provides the index values for all zip codes within the Cleveland Clinic Children's Community.

Figure 56: Mental Health Index



Highlighted Demographics: Children's COVID-19 Impacts Snapshot

On March 13, 2020, a U.S. national emergency was declared over the novel coronavirus outbreak first reported in the Wuhan Province of China in December 2019. Officially named COVID-19 by the World Health Organization (WHO) in February, WHO declared COVID-19 a pandemic on March 11, 2020. Later that month, stay-at-home orders were placed by the Ohio Governor followed by school closures and soaring unemployment as companies were impacted and mass layoffs began.

At the time that the Cleveland Clinic Children's Community began its collaborative CHNA process, the community and the state of Ohio were in a period of the pandemic that was hoped to be in its final phases. Primary data was collected virtually to ensure the health and safety of those participating.

COVID-19 Pandemic

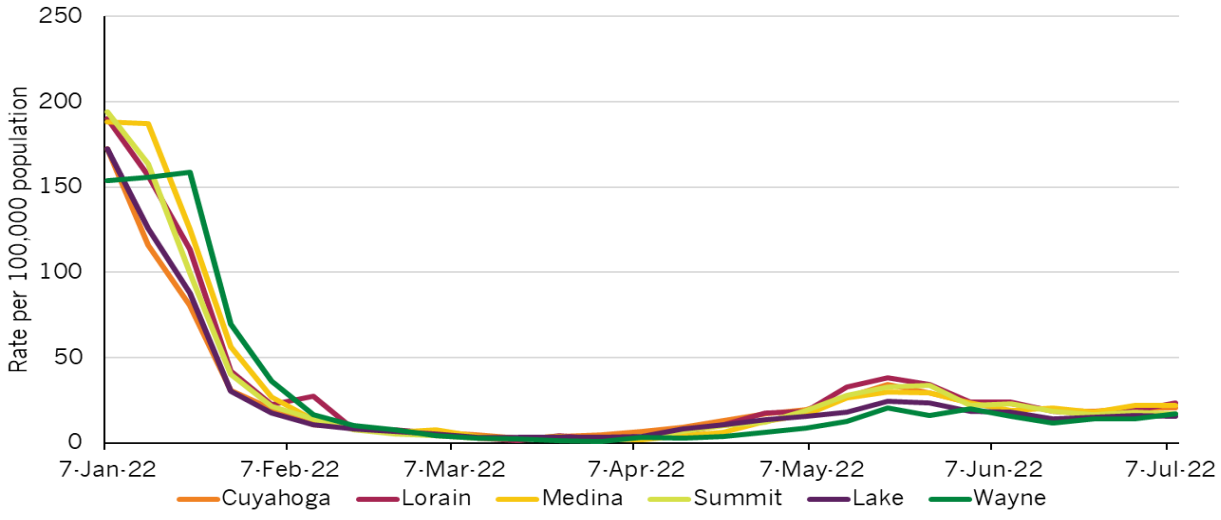
Community Input

Key stakeholders served to assess the impact of the COVID-19 pandemic by asking respondents to describe how the pandemic has impacted community health outputs. Top responses specific to children's health focused on mental health, learning loss and increases in abuse and lead exposure positively correlated with time children spent indoors. Children's mental health suffered as social isolation stunted social and emotional development. The transition from in-person learning to virtual classrooms resulted in education gaps and lost knowledge.

The COVID-19 Daily Average Case Incidence Rate by County

Figure 57 shows the daily average COVID-19 case incidence rate for Cuyahoga, Lake, Lorain, Medina, Summit, and Wayne counties. As shown, the incidence rate has declined for all counties since the beginning of 2022, although some small spikes in incidence rates have occurred.

Figure 57: COVID-19 Daily Average Case Incidence Rate by County



County values· Centers for Disease Control and Prevention (2022)

Vaccination Rates

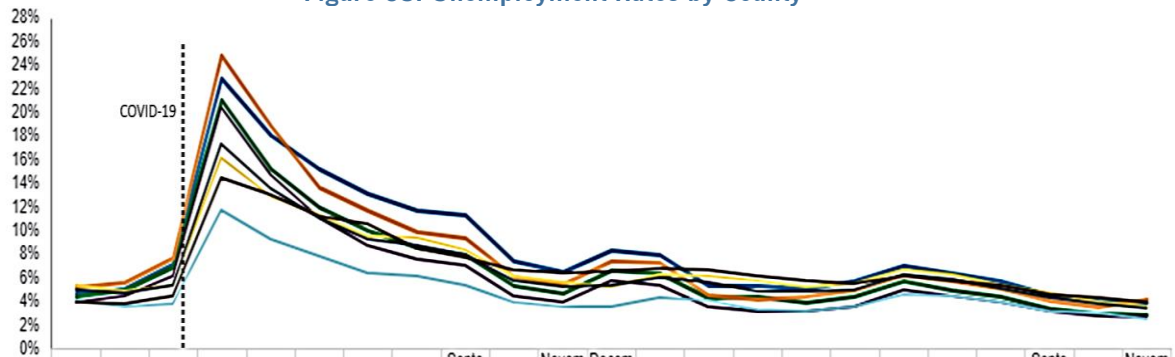
As of June 2022, at least 46% of the population residing in the counties within the Cleveland Clinic Children's Community Definition are fully vaccinated against COVID-19. Lake County has the highest vaccination rates (66.2%), followed by Cuyahoga County (65.5%), Medina County (64.6%), Lorain County (64.5%), Summit County (64%), and Wayne County (46.1%). The population 12+ who are fully vaccinated against COVID-19 is 73.6% in Cuyahoga County, 73.5% in Lake County, 72.6% in Lorain County, 72.3% in Medina County, 71.6% in Summit County, and 53.5% in Wayne County.

Unemployment Rates

Unemployment rates rose between March and April 2020 for Cuyahoga and Lake counties when stay-at-home orders were first announced. Illustrated in Figure 58 below, as counties began slowly reopening some businesses in late-2020, the unemployment rate gradually began to go down. As of late 2021, unemployment rates have stabilized but still exceed pre-pandemic rates.

Data suggests that the percent of children with an unemployed parent reached historic highs during the pandemic [43]. Reductions in family income, especially if the family's income drops below poverty levels, can affect children's development. Children in poverty may have more limited access to healthcare, nutritious meals, and safe childcare, especially if a family's income remains under poverty thresholds for six months or longer[44].

Figure 58: Unemployment Rates by County



	January 2020	February 2020	March 2020	April 2020	May 2020	June 2020	July 2020	August 2020	September 2020	October 2020	November 2020	December 2020	January 2021	February 2021	March 2021	April 2021	May 2021	June 2021	July 2021	August 2021	September 2021	October 2021	November 2021
Cuyahoga	4.7%	5.1%	7.2%	22.9%	18.1%	15.2%	13.1%	11.7%	11.3%	7.4%	6.5%	8.3%	7.9%	5.3%	5.4%	5.1%	5.7%	7.1%	6.4%	5.8%	4.6%	4.1%	3.9%
Lake	4.5%	5.0%	6.9%	21.1%	15.2%	12.0%	10.0%	8.6%	8.0%	5.3%	4.7%	6.7%	6.4%	4.3%	4.5%	3.9%	4.4%	5.7%	5.0%	4.5%	3.4%	3.0%	2.9%
Lorain	5.2%	5.6%	7.7%	24.8%	18.9%	13.7%	11.7%	9.9%	9.4%	6.1%	5.5%	7.5%	7.3%	4.6%	4.2%	4.5%	5.0%	6.3%	5.8%	5.1%	4.1%	3.6%	4.2%
Medina	4.0%	4.4%	6.1%	20.4%	14.7%	11.1%	8.8%	7.6%	7.1%	4.5%	4.0%	5.7%	5.4%	3.5%	3.2%	3.1%	3.6%	5.0%	4.5%	4.0%	3.1%	2.8%	2.7%
Summit	5.3%	4.8%	5.3%	16.2%	12.9%	11.4%	9.5%	9.4%	8.4%	6.2%	5.6%	5.2%	6.3%	6.2%	5.7%	5.2%	5.5%	6.6%	6.3%	5.4%	4.7%	4.0%	3.6%
Wayne	4.1%	3.6%	3.8%	11.7%	9.3%	7.8%	6.4%	6.1%	5.4%	4.0%	3.6%	3.6%	4.3%	4.1%	3.3%	3.2%	3.5%	4.6%	4.5%	3.9%	3.2%	3.0%	2.5%
Ohio	5.0%	4.7%	5.4%	17.3%	13.5%	11.1%	9.2%	8.8%	8.0%	5.8%	5.2%	5.3%	6.0%	5.6%	4.9%	4.8%	5.0%	6.3%	5.9%	5.1%	4.3%	3.8%	3.4%
U.S.	4.0%	3.8%	4.5%	14.4%	13.0%	11.2%	10.5%	8.5%	7.7%	6.6%	6.4%	6.5%	6.8%	6.6%	6.2%	5.7%	5.5%	6.1%	5.7%	5.3%	4.6%	4.3%	3.9%

County, State, and National Values- Bureau of Labor Statistics (2020-2021)

[43] Parolin Z. Unemployment and child health during COVID-19 in the USA. Lancet Public Health. 2020 Oct;5(10):e521-e522. doi: 10.1016/S2468-2667(20)30207-3. PMID: 33007208; PMCID: PMC7524545.
[44] Isaacs, J. Unemployment from a Child's Perspective. Washington, DC: Urban Institute, 2013. https://www.urban.org/sites/default/files/publication/23131/1001671-Unemployment-from-a-Child-s-Perspective.PDF

Cleveland Clinic Children's Synthesis and Prioritization

All forms of data may present strengths and limitations. Each data source used in this CHNA process was evaluated based on strengths and limitations and should be kept in mind when reviewing this report. Each health topic presented a varying scope and depth of quantitative data indicators and qualitative findings. For both quantitative and qualitative data, immense efforts were made to include as wide a range of secondary data indicators, and key stakeholders as possible. A full list of contributors can be found in the Primary Data Collection and Analysis description in Appendix A.

To gain a comprehensive understanding of the significant health needs for the Cleveland Clinic Children's Community, the findings from both data sets were compared and studied simultaneously. The secondary data scores and key stakeholder responses were considered equally important in understanding the health issues of the community. Each of the five top health needs identified from these data sources were included in the prioritized health needs. To ensure alignment with state and local health department objectives, a working group analyzed these significant health needs alongside the Ohio State Health Improvement Plan (SHIP) as well as the Cuyahoga, Lake, Lorain, Medina, Summit and Wayne County Community Health Improvement Plans (CHIP) most recent findings.

The five identified health needs outlined in Figure 27 are addressed in four of the prioritized health needs for children. Each prioritized health topic includes the key findings from secondary data and key stakeholder interviews.

Prioritized Health Topic #1: Access to Healthcare

Access to Healthcare

Key Themes from Community Input

- Barriers: transportation, health illiteracy, hours of operation
- Children's immunizations were delayed as a result of COVID-19
- Difficulties navigating health care system due to lack of broadband access/computer knowledge, no prior experience as a healthcare consumer/history of accessing the system
- Gentrification/Built Environment reduces accessibility to services
- Issues of discrimination/bias create mistrust in healthcare: having doctors that look like the people they're serving, building a sustainable presence in the community, mobile health units, easily available translators, culturally responsive health care providers to implement trauma-informed care/gender-affirming care
- Lack of investment in local public health/preventive care as hospitals are focused on revenue coming from speciality/surgical care
- Racial, economical, geographical, educational, environmental inequities all affect access to care, disproportionately impacting communities of color
- Red lined communities have decreased healthcare access
- Systemic inequities in payment structures: conditions that communities of color were experiencing are reimbursed at lower rates than the conditions that White people are reimbursed for

PRIMARY DATA: KEY STAKEHOLDER INTERVIEWS

Parental access to healthcare impacts children and key stakeholders spoke at lengths about the barriers they face in accessing health services. Key stakeholders noted a lack of investment in prevention practices including accessibility of primary services at a local level. Racial, economic, geographic, educational and environmental inequities all impact access to care and disproportionately affect communities of color and their children. Three key themes surfaced from community discussions including systemic inequities in healthcare, the need to focus on preventative care, and barriers to healthcare.

Systemic inequities in healthcare included issues of discrimination and bias from providers which ultimately creates mistrust from communities experiencing this discrimination. Key informants suggested hiring providers that look like the people they are caring for, building a sustainable presence in the community, and ensuring providers are trained in trauma-informed care and gender-affirming care.

Preventative care included high utilization rates of the ER for minor health issues due to lack of primary care physician, and the need to strengthen the public health infrastructure. Furthermore, COVID-19 allowed for the expansion of telehealth which increased access to healthcare for many. However, it also exposed the inequities in broadband support due to infrastructure issues leaving residents unable to access telehealth.

Barriers to healthcare included transportation, navigating the difficulties of a fragmented healthcare system, ability to pay for services/insurance (lack of insurance, high co-pays/deductibles), and health literacy for providers to communicate with patients.

Prioritized Health Topic #2: Behavioral Health

Behavioral Health: Mental Health

Key Themes from Community Input

- Closely linked with substance use as self-medication
- Housing insecurity especially for younger LGBT individuals leading to homelessness effects mental wellbeing
- Lack of meaningful investment in true community health programming
- Lack of providers to meet the increasing mental health/behavioral health needs and psychiatrists with prescribing abilities
- Mental health issues worsened for LGBTQ+ population, children, college students, teens & teachers as a result of COVID-19 isolation
- Need to expand provider network as the justice system works to divert folks with low-level violations to treatment and mental health care
- Resources needed to help develop coping strategies & resilience from trained/supportive professionals
- Second leading cause of death in kids 10-14 is suicide
- Social isolation worsened during pandemic leading to a spike in reports of depression, anxiety, suicide attempts or death by suicide
- Transgender patients have a much higher risk of suicide due to discrimination, bigotry & isolation

PRIMARY DATA: KEY STAKEHOLDER INTERVIEWS

Key stakeholders focused on the high level of despair and mental illness for children in their communities, which has been exacerbated by the COVID-19 pandemic. This, coupled with trauma from social isolation has led to a spike in reports of depression, anxiety, suicides attempt, or death by suicide. Related to learning loss and pandemic associated isolation, mental and behavioral health issues, including substance abuse have challenged children at increasingly younger ages. Further, the lack of mental health providers worsening the challenges of meeting the increased demand for mental health needs. They corroborated this description of the increasing mental health needs of children and adolescents citing state statistics showing that suicide is the second leading cause of death in children ages 10-14 years.

Stakeholders recommended an increase in meaningful investment in community health programming, as well as working alongside the network of community behavioral health organizations. Mental Health issues worsened for the LGBTQ+ population during COVID-19, a population that already has increased rates of mental health illness. Stakeholders mentioned the discrimination and bigotry LGBTQ+ children face, further highlighting the urgent need to address these unmet health needs.

Prioritized Health Topic #3: Chronic Disease Prevention and Management

Nutrition & Healthy Eating

Key Themes from Community Input

- Access to healthy food limited by transportation, minimal grocery stores nearby, built environment, affordability
- Effects of redlining are still seen—these are the neighborhoods that do not always have grocery stores in a close mile radius
- COVID-19 impacted the need for food and levels of food insecurity: i.e. homebound individuals, children reliant on school breakfast/lunch
- High incidence of chronic health conditions like heart disease, diabetes, obesity, cancer in communities without high quality food access as these conditions are all inherently tied to healthy food accessibility, built environment/walkability, safety, access to care
- Low-income communities are disproportionately lacking stores with healthy fresh food and often don't have internet access to order food online

Chronic Disease Prevention and Management is a health topic that is analyzed from four secondary data topics – Nutrition and Healthy Eating, Chronic Diseases and Cancer. An overview snapshot of each relevant subtopic for which data are available is provided below.

PRIMARY DATA: KEY STAKEHOLDER INTERVIEWS

Stakeholders considered nutrition for low-income families a key concern with risks to childhood obesity and juvenile diabetes as early life precursors to chronic diseases top of mind. Key stakeholders further revealed that access to healthy food was often limited by a lack of either public or private transportation. There are only a few grocery stores in the community and few community members can access those by walking. Conditions such as hypertension, asthma, diabetes, chronic obstructive pulmonary disease (COPD) and coronary heart disease are all related to the quality of food community members have access to1. Ensuring children and families have access to healthy food, is a public health approach to preventing chronic diseases later in life. COVID-19 greatly impacted levels of food insecurity as many children are reliant on free and reduced-price school meals, including breakfast and lunches. With school shutdowns, this source of nutrition for children was virtually nonexistent. Key stakeholders emphasized the link between food and proper childhood development as well.

Prioritized Health Topic #4: Maternal and Child Health

Maternal & Child Health

Key Themes from Community Input

- All issues are disproportionately impacting poor children
- Many AAPI (Asian American and Pacific Islander) families made the decision that their kids were safer at home, not necessarily from COVID-19, but from physical, anti-Asian hostilities. So, they kept their kids at home and that's devastating because engagement in learning is extremely difficult in that remote setting
- Opportunity for payer community to pay for food for pregnant people experiencing food insecurity to have better pregnancy outcomes
- Poor quality housing is directly attributable to things like asthma and lead poisoning
- Red lined communities are also most impacted by lead and infant mortality
- Specialized resources need to be allocated to communities most impacted by infant mortality, prematurity, early pregnancy loss which is African American families to promote true health equity
- There needs to be more intentional funding of maternal/infant health programs in the community from the hospital using an equity lens
- Top issues: lead poisoning, mental/behavioral health, infant mortality, food insecurity, delays in preventative care, learning loss

Warning Indicators

- Babies with Low Birth Weight
- Children with Low Access to a Grocery Store
- Consumer Expenditures: Childcare
- Mothers who Received Early Prenatal Care

PRIMARY DATA: KEY STAKEHOLDER INTERVIEWS

Key stakeholder interviews acknowledged the persistence of high infant mortality rates as well as the continuance of lead poisoning as a contributor to poor children's health outcomes. During the COVID-19 pandemic, long periods of time spent indoors increased exposures and worsened lead related incidents and outcomes. Stakeholders emphasized the relationship between poor quality housing and respiratory health, including asthma.

Children across the service area suffered some learning loss during the pandemic as classrooms went remote and parents were often unable to provide time away from work to attend to their child's educational needs. Parents identifying as Asian American and Pacific Islander (AAPI) reportedly opted to continue with remote options even after in-person learning resumed for fear of anti-Asian sentiment being expressed to their children by classmates.

Related to learning loss and pandemic associated isolation, mental and behavioral health, including substance abuse has challenged children at increasingly younger ages. Isolation also kept parents from seeking primary care services for their children, including immunizations and well child visits. Finally, key stakeholders expressed disparities among low-income children that exacerbated nearly all health outcomes discussed.

According to the secondary data, Maternal, Fetal & Infant Health as well as Children's Health were identified as topic areas of concern. Further analysis was done to identify specific indicators of concern within this topic area. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and can be found in Appendix C and are discussed below. In addition, the appendices also contain a description of methodology (Appendix A) and a full list of indicators with data scoring categorized within this topic area (Appendix C).

Children with Low Access to a Grocery Store is the worst performing indicator in Lake County. In Lake County, eight percent of children live more than one mile from a supermarket or large grocery store.

Consumer Expenditures: Childcare came up as an indicator of concern in Lake, Lorain, Summit and Medina counties. In Lake County, residents spend an average of $315 per consumer unit. A consumer unit is defined as a household or any person living in a college dormitory. This data captures childcare, day care, nursery school, preschool, and non-institutional day camps. [45]Childcare is a major household expense for families with young children. Access to affordable and high-quality childcare is essential for parents to be able to provide sufficient income for their family while ensuring all their children's social and educational needs are met. In regions where childcare costs are high, family budgets are strained, and parents may be forced to sacrifice the quality of childcare arrangements they select for their children. [46]

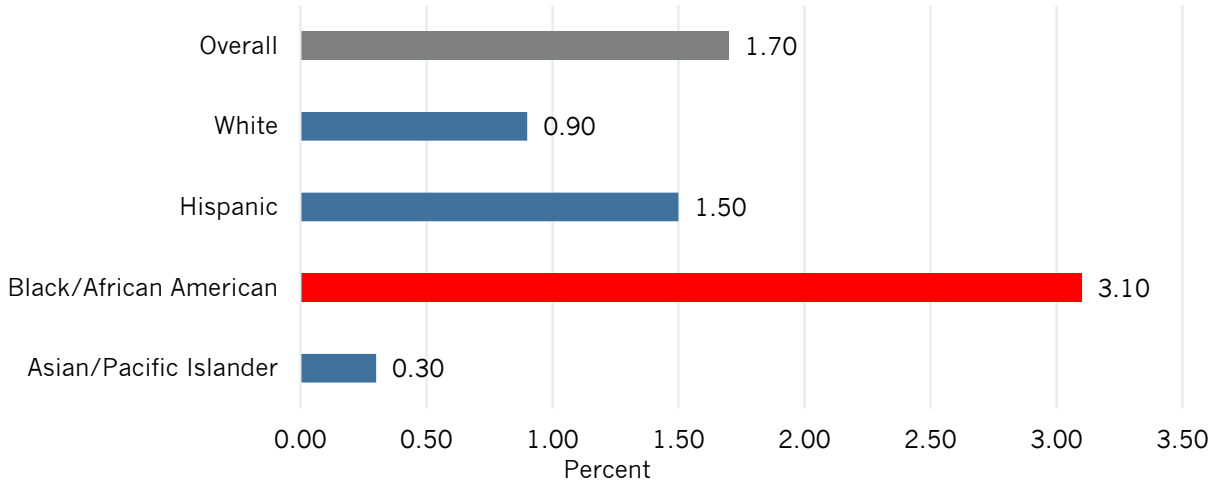
In Wayne County, the Infant Mortality Rate is 9 deaths per 1,000 live births for infants within their first year of life. This is higher than the Ohio state value (6.9) and the HP2030 target value of 5.

Babies with Low Birth Weight and Babies with Very Low Birth Weight are the worst performing indicators in both Cuyahoga and Summit Counties. In Summit County, 9.4% of newborns weighed less than 2,500 grams (5 pounds, 8 ounces) and 1.7% of newborns weighed less than 1,500 grams (3 pounds, 5 ounces). In Cuyahoga County, 10.8% of newborns weighed less than 2,500 grams (5 pounds, 8 ounces) and 1.7% of newborns weighed less than 1,500 grams (3 pounds, 5 ounces). In Cuyahoga, the county rates are higher than the state of Ohio where 8.5% of babies are categorized as having a low birth weight and 1.4% have a very low birth weight (1,500 grams or less).

Additionally, Black/African American residents in Cuyahoga County see a higher rate of Babies with Very Low Birth Weight, as shown in Figure 59 where 3.10% of babies weigh less than 1,500 grams.

[45] Claritas Consumer Buying Power
[46] Center for American Progress, 2021

Figure 59. Babies with Very Low Birth Weight by Race/Ethnicity in Cuyahoga County



Source: Ohio Department of Health, Vital Statistics, 2020

Prioritized Health Topic #5: Socioeconomic Issues

Education

Key Themes from Community Input

- Areas of segregation, high concentrations of poverty tend to have lower quality education opportunities
- Childhood literacy and people being able to ensure that their children are being read to is a big issue
- COVID-19 school closures opened up world of issues, all of which disproportionately effect low-income children:
  - Learning challenges
  - Connection challenges in terms of technology/internet (many students didn't have access to stable Wi-Fi with necessary bandwidth)
  - Children reliant on school meals not being fed
  - Learning loss and link between food and learning
  - Many children were lost to the system as the school didn't have "eyes" on them
- Many AAPI (Asian American and Pacific Islander) families made the decision that their kids were safer at home, not necessarily from COVID-19, but from physical, anti-Asian hostilities
- Need for universal free daycare/preschool at the same caliber for all children

Warning Indicators

- 4th Grade Students Proficient in Math
- 8th Grade Students Proficient in Math
- Consumer Expenditures: Childcare
- Consumer Expenditures: Education
- Student-to-Teacher Ratio

PRIMARY DATA: KEY STAKEHOLDER INTERVIEWS

Key stakeholders couched discussions around the impact of COVID-19 school closures on education, child development, and other issues, all of which are disproportionately affecting low-income children. Many children didn't have the ability to do their schoolwork remotely because they didn't have access to stable Wi-Fi with the necessary bandwidth to serve their needs. Of particular concern, was the fact that a lot of kids during these shutdowns and remote schooling were "lost to the system" as they did not have school counselors and teachers to ensure they were safe and had their needs met.

Children across the service area suffered some learning loss during the pandemic as classrooms went remote and parents were often unable to provide time away from work to attend to their child's educational needs. Parents identifying as Asian American and Pacific Islander (AAPI) reportedly opted to continue with remote options even after in-person learning resumed for fear of anti-Asian sentiment being expressed to their children by classmates.

Finally, stakeholders emphasized the need for universal free daycare and preschool opportunities for all children that's at the same caliber, ensuring children are ready to learn when entering school. Family support for those with young children is needed to ensure children are able to read at the adequate grade level, and as way to address literacy issues.

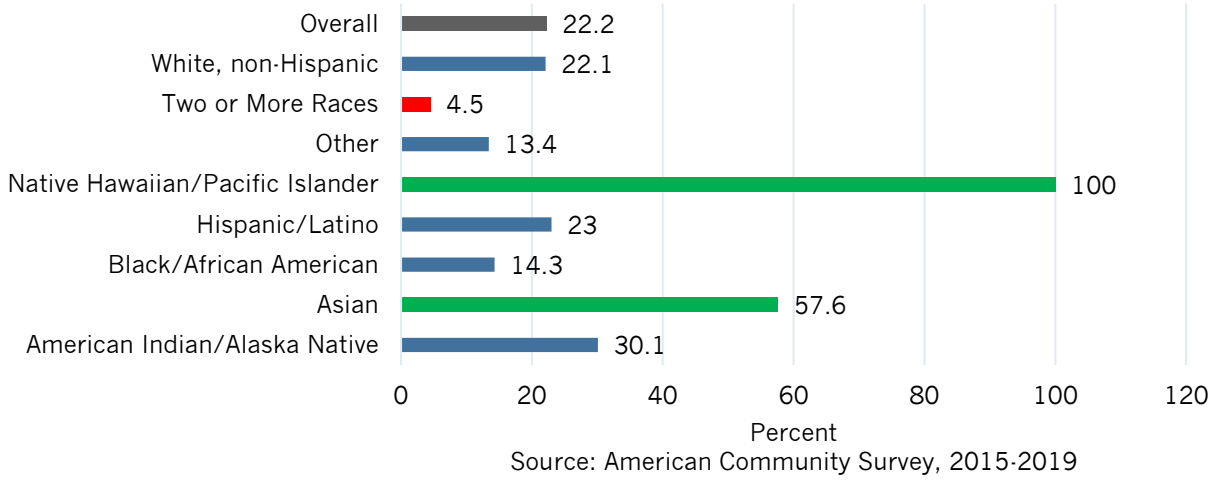
Education was identified as a topic area of concern, according to the secondary data. Further analysis was done to identify specific indicators of concern within this topic area. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and can be found in Appendix C and are discussed below. In addition, the appendices also contain a description of methodology (Appendix A) and a full list of indicators with data scoring categorized within this topic area (Appendix C).

8th Grade Students Proficient in Math and English/Language Arts scored poorly in both Cuyahoga and Lake counties. Both counties fall in the lowest quartile of all counties in Ohio. In Cuyahoga County, 4th Grade Students Proficient in Math and English/Language Arts also came up as areas of concern and similarly Cuyahoga County falls in the lowest quartile of all counties in Ohio for both indicators.

In Lake County, the student-to-teacher ratio of 18.5 is increasing and Lake County is in the lowest quartile of all counties in the United States. Similarly, the student-to-teacher ratio is 16.2 in Wayne County and increasing.

In Wayne County, when looking at People 25+ with a Bachelor's Degree or Higher, disparities exist for residents who identify as two or more races. As seen in Figure 60, 4.5% of residents who identify as two or more races have a bachelor's degree or higher.

Figure 60. People 25+ with a Bachelor's Degree or Higher by Race/Ethnicity in Wayne County



Source: American Community Survey, 2015-2019

Appendices Summary

A. Methodology

An overview of methods used to collect and analyze data from both secondary and primary sources.

B. Impact Evaluation

A detailed overview of progress made on the 2019 Implementation Strategy planning, development and roll-out as well as email and web contacts for more information on the 2022 CHNA.

C. Secondary Data Methodology and Scoring Tables

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

D. Community Input Assessment Tools

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

- Community Engagement Session Questions
- Key Stakeholder Interview Questions
- Key Stakeholder and Community Organizations

E. Community Partners and Resources

The tables in this section acknowledge community partners and organizations who supported the CHNA process.

F. Acknowledgements

Appendix A: Methodology

Overview

Primary and secondary data were collected and analyzed to inform the 2022 CHNA. Primary data consisted of community engagement session discussions and key stakeholder interviews. The secondary data included indicators of health outcomes, health behaviors and social determinants of health. The methods used to analyze each type of data are outlined below. This analysis was conducted at the county-level.The findings from each data source were then synthesized and organized by health topic to present a comprehensive overview of health needs in the Cleveland Clinic Main Campus Community and Cleveland Clinic Children's Community.

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. The following is a list of both local and national sources used in the Cleveland Clinic Main Campus Community and Cleveland Clinic Children's 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 Buying Power
- Claritas Consumer Profiles
- County Health Rankings
- Feeding America
- Healthy Communities Institute
- 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

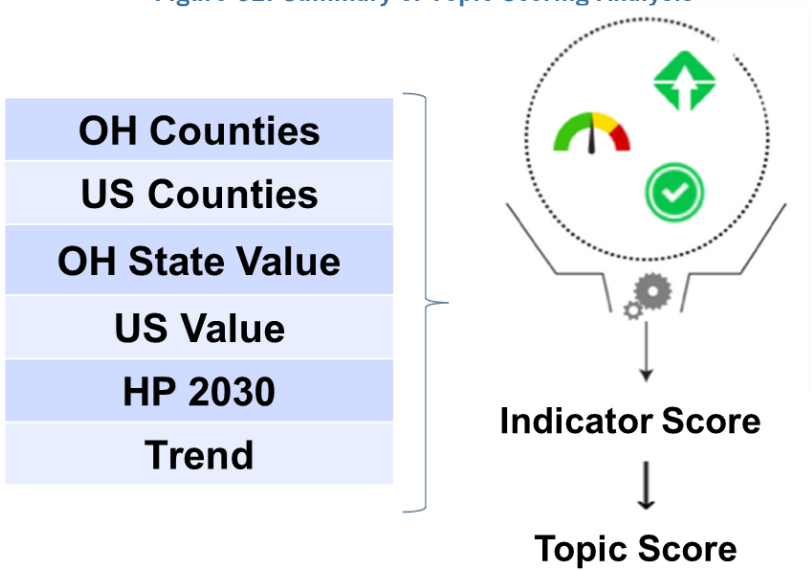
- Ohio Secretary of State
- U.S. Bureau of Labor Statistics
- U.S. Census - County Business Patterns
- U.S. Department of Agriculture - Food Environment Atlas
- U.S. Environmental Protection Agency
- United For ALICE

Secondary data used for this assessment were collected and analyzed from HCI's community indicator database. This database, maintained by researchers and analysts at HCI, includes 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.

Secondary Data Scoring

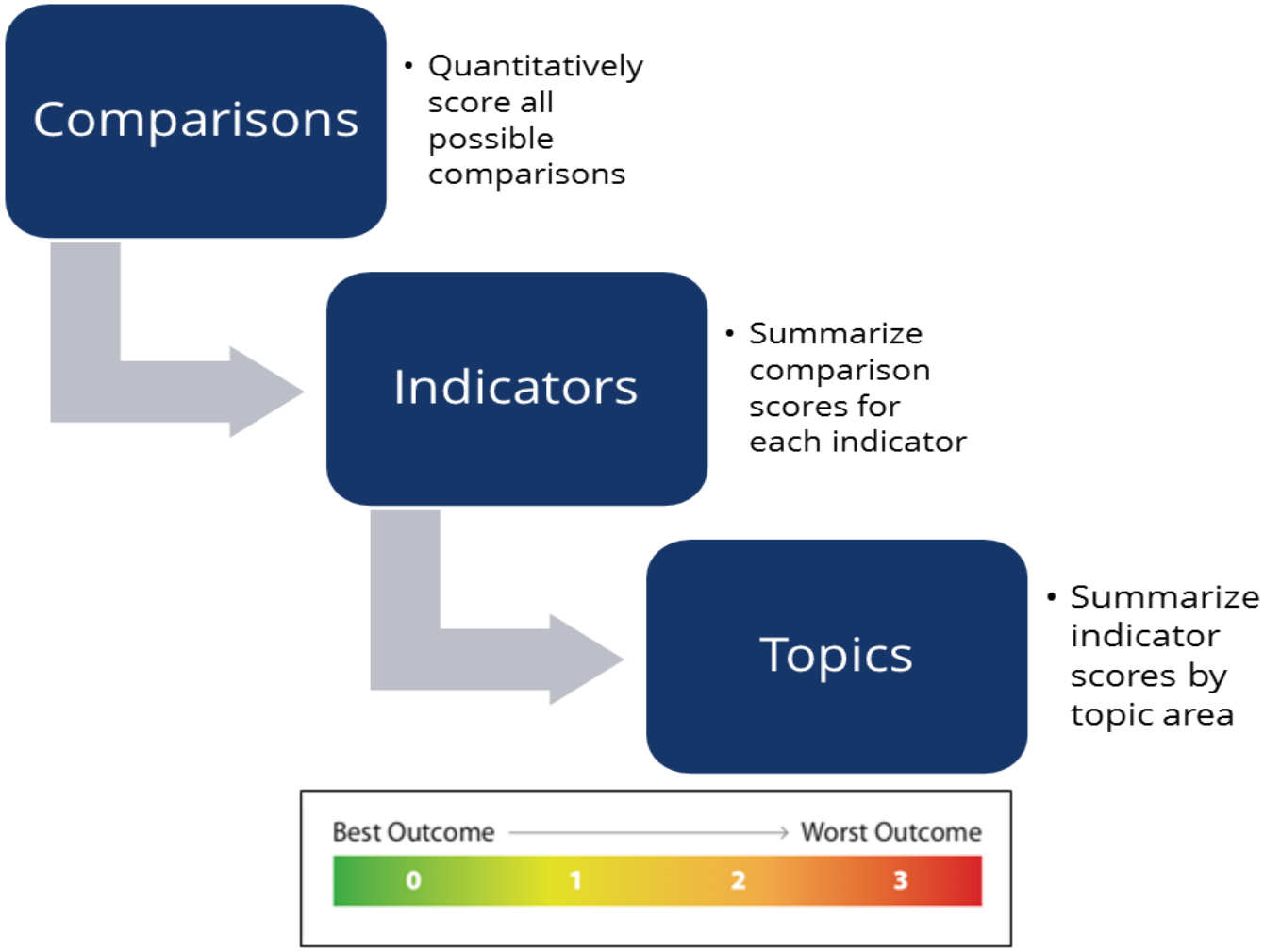
HCI's Data Scoring Tool (Figure 61) was used to systematically summarize multiple comparisons in order to rank indicators based on highest need. This analysis was completed at the county level. For each indicator, the community value was compared to a distribution of Ohio and US counties, state and national values, Healthy People 2030, and significant trends were noted. These comparison scores range from 0-3, where 0 indicates the best outcome and 3 the worst. Availability of each type of comparison varies by indicator and is dependent upon the data source, comparability with data collected for other communities and changes in methodology over time. The comparison scores were summarized for each indicator, and indicators were then grouped into topic areas for a systematic ranking of community health needs.

Figure 61: Summary of Topic Scoring Analysis



Secondary Data Scoring

Data scoring is done in three stages:



Each indicator available is assigned a score based on its comparison to other communities, whether health targets have been met, and the trend of the indicator value over time. These comparison scores range from 0-3, where 0 indicates the best outcome and 3 the worst. Availability of each type of comparison varies by indicator and is dependent upon the data source, comparability with data collected for other communities and changes in methodology over time.
Indicators are categorized into topic areas and each topic area receives a score. Indicators may be categorized in more than one topic area. Topic scores are determined by the comparisons of all indicators within the topic.
This process was completed for the counties within the Cleveland Clinic Main Campus Community: Cuyahoga and Cleveland Clinic Children's Community: Cuyahoga, Lake, Lorain, Medina, Summit, and Wayne. To calculate the overall highest needs topic area scores, an average was taken for each topic area across the three counties. Each county's values were weighted the same. More details about topics scores and the average score for the Cleveland Clinic Main Campus Community, see Appendix C.

Comparison to a Distribution of County Values: Within State and Nation

For ease of interpretation and analysis, indicator data on the Community Dashboard is visually represented as a green-yellow-red gauge showing how the community is faring against a distribution of counties in the state or the United States. 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, red) based on their order. Indicators with the poorest comparisons ("in the red") scored high, whereas indicators with good comparisons ("in the green") scored low.

Comparison to Values: State, National, and Targets

Each county is compared to the state value, the national value, and target values. Target values include the nation-wide Healthy People 2030 (HP2030) goals. Healthy People 2030 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 better or worse 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 the 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 on the community dashboard, it will be included in the

indicator score. After exclusion of comparison types with inadequate availability, all missing comparisons are substituted with a neutral score for the purposes of calculating the indicator's weighted average. When information is unknown due to lack of comparable data, the neutral value assumes that the missing comparison score is neither good nor bad.

Indicator Scoring

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

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 0-3, where a higher score indicates a greater level of need as evidenced by the data. A topic score is only calculated if it includes at least three indicators.
Examples of the health and quality of life topic areas available through this analysis are described as follows:

Quality of Life	Health	
Community	Adolescent Health	Older Adults
Economy	Alcohol & Drug Use	Oral Health
Education	Cancer	Other Conditions
Environmental Health	Children's Health	Prevention & Safety
	Diabetes	Physical Activity
	Health Care Access and Quality	Respiratory Diseases
	Heart Disease & Stroke	Sexually Transmitted Infections
	Immunization & Infectious Diseases	Tobacco Use
	Maternal, Fetal & Infant Health	Women's Health
	Medications & Prescriptions	Wellness & Lifestyle
	Mental Health & Mental Disorders	Weight Status
	Nutrition & Healthy Eating	

Table 3 shows the health and quality of life topic scoring results for the Cleveland Clinic Main Campus and Cleveland Clinic Children's Community. These topics are ranked in order of highest need. Prevention & Safety scored as the poorest performing topic area with a score of 2.21, followed by Other Conditions with a score of 1.83. Topics that received a score of 1.50 or higher

were considered a significant health need. Twelve topics scored at or above the threshold. Topic areas with fewer than three indicators were considered a data gap.

Table 3: Top Secondary Data Health Needs: Cleveland Clinic Main Campus

Top Secondary Data Health Needs
Prevention & Safety
Other Conditions
Alcohol & Drug Use
Children's Health
Medications & Prescriptions
Cancer
Older Adults
Economy
Community
Education
Environmental Health
Maternal, Fetal and Infant Health

Table 4 shows the health and quality of life topic scoring results relevant for the Cleveland Clinic Children's Community. These topics are ranked in order of highest need. Children's Health had a topic score of 1.49, followed by Education with a score of 1.47.

Table 4: Top Secondary Data Health Needs: Children's Community

Top Secondary Data Health Needs
Children's Health
Education
Maternal, Fetal and Infant Health

Index of Disparity

An important part of the CHNA process is to identify health disparities, the needs of vulnerable populations and unmet health needs or gaps in services. There were several ways in which subpopulation disparities were examined by county. For secondary data health indicators, the Index of Disparity tool was utilized to see if there were large, negative, and concerning differences in indicator values between each subgroup data value and the overall county value. The Index of Disparity was run for each county, and the indicators with the highest race or ethnicity index value were found.

Health Equity Index

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

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 U.S. Communities with the highest index values are estimated to have the highest socioeconomic needs correlated with preventable hospitalizations and premature death.

What do the ranks and colors mean?

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

Food Insecurity Index

Every community can be described by various health, social, and economic factors that can contribute to disparities in outcomes and opportunities to thrive. 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 U.S. Communities with the highest index values are estimated to have the highest food insecurity, which is correlated with household and community measures of food-related financial 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 Food Insecurity Index, with darker coloring associated with higher relative need.

Mental Health Index

Every community can be described by various health, social, and economic factors that can contribute to disparities in mental 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 poor mental health.

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 U.S. Communities with the highest index values are estimated to have the highest socioeconomic and health needs correlated with 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 Mental Health Index, with darker coloring associated with higher relative need.

Tables 5 and 6 list each zip code within the Cleveland Clinic Main Campus Community and Clevelant Clinic Children's community, respectively, and their respective HEI, FII, and MHI values.

Table 5: HEI, FII and MHI Values for Zip Codes within the Cleveland Clinic Main Campus Community

Zip Code	HEI Value	FII Value	MHI Value
44102	96.7	96.6	98.3
44103	99.3	98.3	100
44104	99.9	99.8	100
44105	98.1	98.2	99.8
44106	88.5	72.4	98.5
44108	98.8	97.6	100
44109	95.6	95.7	97.4
44110	98.6	98.4	99.9
44112	96.6	97.6	99.9
44113	85	65.8	95.8
44114	96.6	84.1	94
44115	99.8	99.4	99.6
44117	80	88	99.2
44118	19.8	41.4	80.5
44120	84	88.4	99.2
44121	49.6	77.5	92.2
44122	7.8	24.1	87.9
44125	70.2	81.3	94.5
44127	99.8	99.2	99.5
44128	92.8	96.1	99.7
44131	10.8	4.9	52.3
44137	82.8	86.2	97.7

Table 6: HEI, FII and MHI Values for Zip Codes within the Cleveland Clinic Children's Community

Zip Code	HEI Value	FII Value	MHI Value
44011	4.4	7.8	21
44012	5	12.9	30
44035	75.4	74	93.9
44039	15.6	15.8	49.1
44050	23.9	39.6	33.9
44052	94.4	93.8	95.6
44053	59.4	61	91.3
44060	17.3	25	61.9
44070	25	25.1	64.7
44077	28.1	40.3	73.6
44087	12.7	19.8	60.7
44090	42.6	42.7	72.4
44102	96.7	96.6	98.3
44103	99.3	98.3	100
44104	99.9	99.8	100
44105	98.1	98.2	99.8
44106	88.5	72.4	98.5
44107	35.3	50.8	77
44108	98.8	97.6	100
44109	95.6	95.7	97.4
44110	98.6	98.4	99.9
44111	85.6	88.1	95.6
44112	96.6	97.6	99.9
44113	85	65.8	95.8
44117	80	88	99.2
44118	19.8	41.4	80.5
44119	85.3	86	97.2
44120	84	88.4	99.2
44121	49.6	77.5	92.2
44122	7.8	24.1	87.9
44123	79.4	89.4	98.3

44124	13	18.5	80.3
44125	70.2	81.3	94.5
44128	92.8	96.1	99.7
44129	42.8	72.2	77.4
44130	36.6	45.8	81.6
44131	10.8	4.9	52.3
44132	81.2	91.6	98.2
44134	45.6	57.3	81.7
44135	92.7	91.1	97.4
44137	82.8	86.2	97.7
44139	4.3	8.6	25.9
44140	2.6	3.7	29.4
44143	20	25.4	89
44144	71	79.5	91.8
44146	53.9	71.2	96.4
44212	16.9	26.6	42.6
44215	48.6	62.5	29
44221	33.6	47.3	62.5
44224	11.7	22.9	57.6
44233	5.8	2.6	29.9
44235	48.1	20.5	12.8
44253	19.6	9.1	4
44254	58.2	63.1	76.4
44256	11.7	19.9	43.3
44280	9.9	8.3	24.2
44281	14.6	24.3	40
44287	59.9	49.9	54.4
44305	80.8	85.6	94.3
44306	96.2	97.3	99
44307	98.3	99.6	99.7
44310	91.5	85.3	90.8
44312	49.7	51.2	84
44313	20.9	40.7	88.1
44314	81.7	86.2	92.9

44320	86.7	91.7	99.1
44321	6.5	9.7	40.5
44333	6.2	7.5	53.3
44606	82.1	46.1	5.8
44685	15.3	16.1	51.4
44691	42.8	42.6	75.4

Data Considerations

Several limitations of data 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 availability 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 not be considered a comprehensive result on their own. In addition, these scores reflect the secondary data results for the population as a whole and do not represent the health or socioeconomic need that is much greater for some subpopulations. Moreover, many of the secondary data indicators included in the findings are collected by survey, and though specific methods are used to best represent the population at large, these measures are subject to instability, especially for smaller populations. The Index of Disparity is also limited by data availability, where indicator data varies based on the population groups and service areas being analyzed.

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 nomenclature. 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 cover ZCTAs or Zip Code Tabulation Areas which were created by the U.S. Census Bureau and are generalized representations of Zip Codes that have been assigned to census blocks.

Demographics for this report are sourced from the United States 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.

Primary Data Collection & Analysis

Primary data used in this assessment consisted of a community engagement session and key stakeholder interviews. These findings expanded upon the information gathered from the secondary data analysis.

Community Engagement Session Methodology and Results

Cleveland Clinic Main Campus invited members of the Stephanie Tubbs Jones Health Center Community Advisory Council (CAC) to participate in a community engagement session. The session was held virtually on May 17, 2022. Participants answered four questions including:

1. What are the most important health problems in the community?
2. What barriers or challenges to improving health exist in your community?
3. What community groups, populations, or neighborhoods are underserved?
4. What can be done to improve the health in your community?

At the end of the session, participants were also asked to describe interventions or programs they are aware of that have been successful in improving health in the community.

The project team captured detailed records of the discussion through transcripts and a polling tool (Poll Everywhere®). Figure 62 shows the results from analysis of inputs collected from these tools.

Figure 62: Community Engagement Session Findings

Key Stakeholder Interviews Methodology and Results

The project team also captured detailed transcripts of the key stakeholder interviews. Table 7 describes the key stakeholder organizations contributing to the primary data collection process.

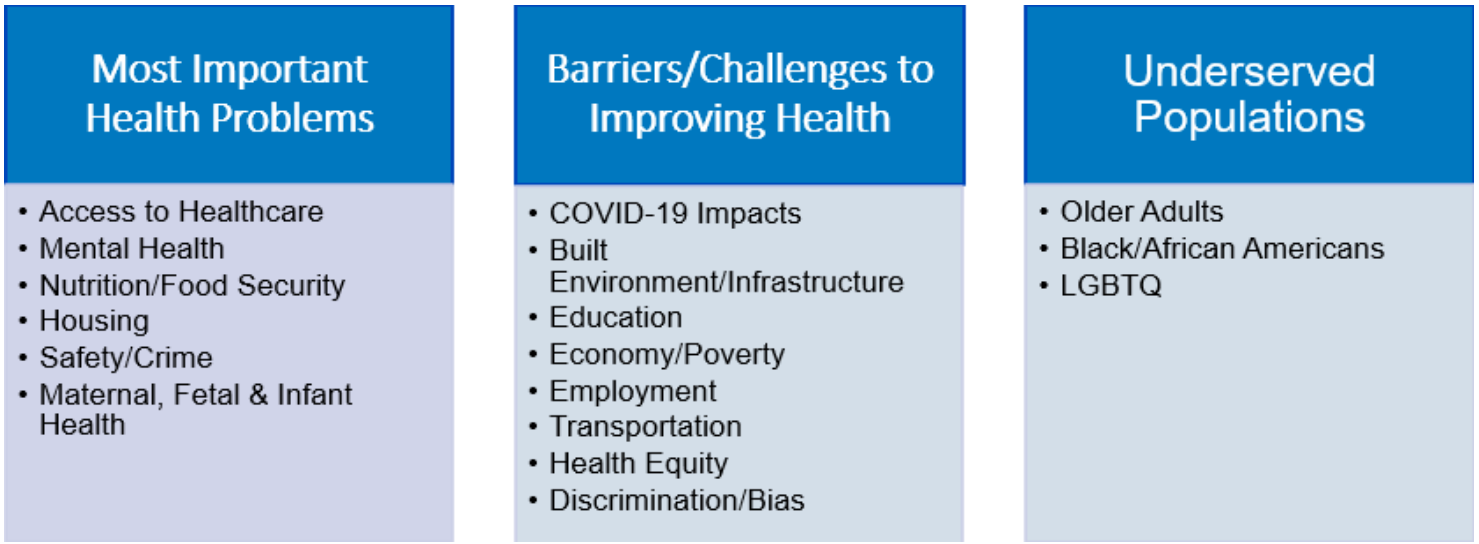
Table 7: Cleveland Clinic Main Campus and Cleveland Clinic Children's Key Stakeholder Organizations

Key Stakeholder and Community Organizations	
• City of Cleveland Department of Public Health • Cuyahoga County Board of Health • Lorain County Public Health • Medina County Health Department • Summit County Public Health	• Neighborhood Family Practice • Birthing Beautiful Communities • Lead Safe Cleveland Coalition • Better Health Partnerships • NAMI Greater Cleveland • Asian Services in Action (ASIA)

• Wayne County Department of Health • Stephanie Tubbs Jones Health Center Community Advisory Council	• Cleveland Clinic LGBTQ+ Care • Benjamin Rose Institute on Aging • Greater Cleveland Food Bank • The Gathering Place • Cuyahoga Metropolitan Housing Authority • Esperanza • The Centers for Families and Children

The transcripts were analyzed using the qualitative analysis program Dedoose 2®. Text was coded using a pre-designed codebook-organized by themes and analyzed for significant observations. Figure 63 shows key findings from community stakeholder interviews specific to the Cleveland Clinic Main Campus Community.

Figure 63: Key Stakeholder Findings



Findings from both the community engagement session and key stakeholder interview analyses were combined with findings from secondary data and incorporated into the Data Synthesis and Prioritized Health Needs.

Appendix B: Impact Evaluation

The CHNA process should be viewed as a three-year cycle to evaluate the impact of actions taken to address priority areas. This step affirms organizations focus and target efforts during the next CHNA cycle. The top health priorities for the Cleveland Clinic Main Campus and Children's Communities from the 2019 CHNAs were:

- Access to Affordable Healthcare
- Addiction and Mental Health
- Chronic Disease Prevention and Management
- Infant Mortality
- Socioeconomic Concerns
- Medical Research and Health Professions Education

Implementation strategies for these health topics shifted in response to the COVID-19 pandemic. Innovative strategies were adopted to continue building capacity for addressing the community health needs.

Actions Taken Since Previous CHNA

Cleveland Clinic Main Campus's previous Implementation Strategy Report (ISR) outlined a plan for addressing the following priorities identified in the 2019 CHNA: Addiction and Mental Health, Chronic Disease Prevention and Management, Infant Mortality, Socioeconomic Concerns, Access to Affordable Health Care, Medical Research and Health Professions Education.

The ISR was conducted before the onset of COVID 19, and therefore, does not reflect the pandemic's impact which dramatically affected community and hospital services. Many of our hospital services were paused or deferred as we navigated the emergent COVID 19 landscape. Caring for our community is essential, and part of that is sharing accurate, up-to-date information on health-related topics with our community. We provided COVID 19 education, vaccine distribution and collaborative services with government, health departments and community based organizations to keep our communities safe. As we continue to serve our communities we are committed to addressing the needs identified in the previous ISR.

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

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

Addiction and Mental Health

Actions and Highlighted Impacts:

a. In addition to direct patient care, Cleveland Clinic's Opioid Awareness Center, provided intervention and treatment for substance abuse disorders to Cleveland Clinic caregivers and their family members.
    - Opioid misuse continues to be a public health emergency, contributing to over 50,000 U.S. deaths a year. About 40% of those deaths involve prescription opioids. Our comprehensive efforts to improve opioid prescribing have yielded reductions in these prescriptions by our providers for two years running, including a large improvement in 2021.
b. Through the Opioid Awareness Center, participated in the Northeast Ohio Hospital Opioid Consortium and Cuyahoga County Opiate Task Force, and community-based classes and presentations. Cleveland Clinic continues to provide preventative education and share evidence-based practices.
c. In partnership with the Cuyahoga County Sheriff's Office Rx Drug Drop Box Program, continues to collect unused opioid and controlled substance medications through community-based drop boxes and a collection service.
d. Cleveland Clinic continues to provide education and resources to caregivers, patients, and their families in order to prevent and address mental health issues.
    - Cleveland Clinic Center for Bioethics collaborated with Mental Health America of Ohio, The Khnemu Foundation, and Bethany Baptist Church to increase the training of community members in Mental Health First Aid (MHFA), a standardized evidence based 8-hour training course to provide individuals with basic skills surrounding mental health issues.
    - Be the Boss of Your Stress, an 8-week school mental health and wellness program, teaches children mind-body coping skills to helpmanage stress, promote healthy lifestyle habits, and includes parent/teacher training. The program, a important component of the Cleveland Clinic Centennial East 100th Street Healthy Community Initiative, was piloted in selected 3rd-5th grade classrooms.

Chronic Disease Prevention and Management

Actions and Highlighted Impacts:

a. Improve management of chronic conditions through Chronic Care Clinics employing a specialized model of care.
    - COVID 19 created a delay in treatment for many community members. We launched an effort to connect patients with care, proactively contacting over 300,000 patients and scheduling 57,000 appointments. This outreach is prompting more patients to complete recommended screening tests, allowing earlier detection of cancers and other diseases when they are most treatable. For example, 1,700 precancerous lesions of the colon have been detected earlier as a result — a key part of preventing colon cancer.

- Outreach initiatives were implemented to screen over patients, community residents, and partners at the onset of COVID 19 to identify and address emergent health needs. Food insecurity, mental health, and finance were the top three needs identified.
- Many in-person community programs were paused by COVD 19. When COVID-19 vaccines became available, we co-led a nationwide campaign to encourage adults to get vaccinated. The coalition of 60 top hospitals and healthcare institutions communicated the vaccines' safety and effectiveness through diverse digital and traditional media. Throughout the years, our health experts explained and advocated the benefits of vaccination at every opportunity, from patient visits to national media appearances. In late 2021, when cases of the omicron variant surged and hospitals filled with unvaccinated patients, we joined with five other Northeast Ohio hospital systems in an advertising campaign urging the public to get vaccinated and take other precautions.

b. Langston Hughes Community Health and Education Center, situated on main campus, provided 5000+ vaccinations to neighborhood residents. Promoted early cancer detection through community outreach and education, screening promotion, and patient navigation. Several programs were held virtually, a collaboration between THE WORD Church and Cleveland Clinic; a partnership between the National Breast Cancer Foundation and Taussig Cancer Institute; and Stopping Cancer in its Tracks, a Cuyahoga County collaborative of 25 churches. A new program, Curbside Mammograms, provided in-person access to services during the pandemic.
c. Provided free cancer screenings through events, such as the annual Minority Health Fair, and Women's Health Initiatives, to screen community members for cancers.
d. Through the Healthy Communities Initiative (HCI), partnered to fund programs designed to improve health outcomes in four core areas: physical activity, nutrition, smoking, and lifestyle management.
    - Prior to COVID 19, Healthy Communities Initiative provided in 23 programs in 59 NE Ohio zip-codes with total participation of 2,813 community residents. Results indicated decreased blood pressure abnormality, increased physical activity and increased healthy eating behaviors.
e. Provided free physical exams, flu shots, exercise courses, health education, cooking classes, and tobacco cessation programs for the surrounding communities at the Cleveland Clinic Langston Hughes Community Health and Education Center in Fairfax.
    - Prior to COVID 19, Langston Hughes provided health education, physical activity and health screenings to Fairfax neighborhood with a 7635 total participation and attendance of over 700 residents, Services are reopening in 2022.

Infant Mortality

Actions and Highlighted Impacts:

a. Provided expanded evidence-based health education to expecting mothers and families
    - Cleveland Clinic provided community education in efforts to support pregnant persons with resources and best practices to reduce infant and maternal health and have a successful pregnancy. Fairview Hospital, Hillcrest

Hospital and Akron General Medical Center provided Childbirth Education and Lactation Services, in-person and virtually, to over 10,000 families in 2020 and over 12,000 families in 2021.
    - We established a Pregnancy Early Assessment Clinic (PEAC) to focus on early pregnancy complications. As one of the few clinics like it in the U.S., the PEAC ensures newly pregnant individuals access the care they need, when they need it.
b. Participated in First Year Cleveland, the Cuyahoga County Infant Mortality Task Force to gather data, align programs, and coordinate a systemic approach to improving infant mortality.
    - In 2020 and 2021 Cleveland Clinic physicians provided clinical and administrative expertise on the Executive Board of First Year Cleveland.
c. Expanded capacity to offer the Centering Pregnancy group prenatal care model to expecting mothers and market the program to community members.
    - Cleveland Clinic is acting to address health disparities and give all infants a healthy start. We expanded Centering programs to bring new mothers together for supportive prenatal care and parenting education. Centering Pregnancy groups provided in-person, virtually and hybrid in Cuyahoga, Summit and Lorain Counties.
    - Cleveland Clinic is providing obstetric navigators to promote maternity care and help parents with food, transport and other socioeconomic needs.
    - Partnering with organizations such as Birthing Beautiful Communities on a navigation project to address social determinants of health for mothers who are at risk who live in zip codes that have a high prevalence of Infant Mortality.
d. Outreach events like Community Baby Showers which provided health information to families in specific high-risk geographical areas and encouraged enrollment in supportive evidence-based programs were paused due to COVID 19. Community health education continued through virtual education and Centering programs.

Socioeconomic Concerns

Actions and Highlighted Impacts:

a. Cleveland Clinic implemented a system-wide social determinants screening tool for adult patients to identify needs such as alcohol abuse, depression, financial strain, food insecurity, intimate partner violence, and stress.
b. We implemented a common community referral data platform to coordinate services and ensure optimal communication.
    - Cleveland Clinic collaborated with Unite Ohio to build a coordinated care network of health and social service providers. Cleveland Clinic went live on the platform on July 2021 and has sent nearly 2,000 referrals with a gap closure of 44%.
c. Cleveland Clinic piloted patient navigation programming within a partnership pathway HUB model using community health workers and/or the co-location of community organizations with hospital facilities.

d. Participated in the Robert Wood Johnson Foundation (RWJF) Cross-Sector Innovation Initiative Project in Cuyahoga County which aims to impact structural racism across various sectors.
    - Cleveland Clinic is an inclusive organization that values diversity and equity. Our caregivers and leaders continue to become more diverse. Among newly hired or promoted leaders in 2021, 21% identify as an underrepresented minority. We will continue to make our caregiver family increasingly inclusive to better serve all our communities.
e. Through a partnership with HIP Cuyahoga, Cleveland Clinic continues to improve community voice within healthcare and social service programming using the Healthy NE Ohio website and collaborative Community Health Needs Assessment process.
f. Sponsored and participated in Say Yes to Education Cleveland, a consortium focused on increasing education levels, fostering population growth, improving college access and spurring economic growth
    - Cleveland Clinic pledged financial support to Say Yes to Education Cleveland and began initiative with True2U Mentoring Program which engages Cleveland Metropolitan School District (CMSD) 8th graders in their paths to career readiness.
g. Provided workforce development and training opportunities for youth K-12 in clinical and non-clinical areas, empowering Northeast Ohio's next generation of leaders.
    - As a member of OneTen, a national coalition to hire, train and promote 1 million Black Americans in 10 years, we hired or promoted over 800 Black caregivers in 2021, exceeding our goal of 500.
    - Cleveland Clinic created initiatives to develop a skilled community youth workforce in vulnerable communities aligning with Health Anchor Network (HAN) and Placed-based Initiatives. Examples include:
        - Connected Career Rounds provided 4,233 middle and high school students from 76 schools across 7 states.
        - Louis Stokes Summer Internships provided high school interns a paid experience with exposure to clinical and non-clinical healthcare roles.
        - Glenville High School Pathways Experience engaged 9-12 graders in career awareness sessions and employment skills training sessions.
        - Students Pathways, in partnership with Tri-C Eastern Campus, provided a program for graduating high school seniors to gain exposure to in-demand clinical and non-clinical roles.
    - In 2021, Cleveland Clinic, an anchor institution in the Cleveland Innovation District, collaborated with the state of Ohio to launch in 2021 an initiative to advance healthcare and digital technology, attract and create new businesses, and train the workforce of the future. The state of Ohio and Cleveland Clinic pledged to contribute a combined $565 million for the district — the largest research investment in our history.
h. Provided transportation on a space-available basis to 1) patients within 5 miles of the Stephanie Tubbs Jones Health Center and Marymount, Euclid, Lutheran, and South Pointe Hospitals and 2) radiation oncology patients within 25 miles of Cleveland Clinic Main Campus, Hillcrest, and Fairview Hospitals.

Access to Affordable Health Care

Actions and Highlighted Impacts:

a. Patient Financial Advocates assisted patients in evaluating eligibility for financial assistance or public health insurance programs.
    - Cleveland Clinic provided medically necessary services to all patients regardless of race, color, creed, gender, country of national origin, or ability to pay. The hospital has a financial assistance policy that is among the most generous in the region that covers both hospital services and physician services provided by physicians employed by the Cleveland Clinic. In 2021, Cleveland Clinic health system provided over $178 million in financial assistance to its communities in Ohio, Florida, and Nevada.
b. Provided parking vouchers to Emergency Department patients on campuses where parking fees are assessed.
c. Provided walk-in care at Express Care Clinics and offer evening and weekend hours.
d. Utilizing medically secure online and mobile platforms, connect patients with Cleveland Clinic providers for telehealth and virtual visits
    - In 2021, Cleveland Clinic provided 841,000 virtual visits.

Medical Research and Health Professions Education

Actions and Highlighted Impacts:

a. Through medical research, advanced clinical techniques, devices and treatment protocols in the areas of cancer, heart disease, diabetes, and others.
    - Research into diseases and potential cures is an investment in people's long-term health.
    - In 2020, COVID-19 highlighted the significance of research in community health. Cleveland Clinic research findings increased knowledge about the virus and how best to respond to it. Our researchers developed the world's first COVID-19 risk-prediction model, enabling healthcare providers to calculate an individual patient's likelihood of testing positive for infection as well as their probable outcome from the disease.
    - For 2021, Cleveland Clinic's community benefit in support of research was $101 million.
b. Through the Center for Populations Health Research, informed clinical interventions, healthcare policy, and community partnerships.
c. Sponsored high-quality medical education training programs for physicians, nurses, and allied health professionals via Graduate Medical Education programs, and internships and residencies.
    - Cleveland Clinic provided a wide range of high-quality medical education that includes accredited training programs for residents, physicians, nurses and allied health professionals. By educating medical professionals, we ensure that the public receives the highest level of medical care and will have access to highly trained health professionals in the future. For 2021, Cleveland Clinic's community benefit in support of education was $322 million.

d. In partnership with Case Western Reserve University, provided over 2,200 students with interdisciplinary skills at the Health Education Campus.
e. Trained future primary care physicians in partnership with the Ohio University Heritage College of Osteopathic Medicine at the Cleveland Clinic South Pointe Campus.
    - 2021 saw the graduation of the first eight students from the Transformative Care Continuum jointly offered by Cleveland Clinic and the Ohio University Heritage College of Osteopathic Medicine. Under this program's accelerated curriculum, nearly two dozen students work alongside our healthcare teams during their medical school training before starting their family medicine residency at our facilities. The aim is to enhance primary care training through a focus on building relationships with patients and their communities.
f. Through the Physician Diversity Scholars Program, continues to build a diverse healthcare workforce in partnership with the Ohio University Heritage College of Osteopathic Medicine.

Community Feedback

Community Health Needs Assessment reports from 2019 were published on the Cleveland Clinic Main Campus and Chidlren's websites. No community feedback has been received as of the drafting of this report. For more information regarding Cleveland Clinic Community Health Needs Assessments and Implementation Strategy reports, please visit www.clevelandclinic.org/CHNAreports or contact CHNA@ccf.org.

Appendix C: Secondary Data Scoring Tables for Cleveland Clinic Main Campus and Cleveland Clinic Children's

Secondary Data Scoring Tables for Cleveland Clinic Main Campus

Table 8: The Cleveland Clinic Main Campus Community Definition

Zip code	Postal Name
44102	Cleveland
44103	Cleveland
44104	Cleveland
44105	Cleveland
44106	Cleveland
44108	Cleveland
44109	Cleveland
44110	Cleveland
44112	Cleveland
44113	Cleveland
44114	Cleveland
44115	Cleveland
44117	Euclid
44118	Cleveland
44120	Cleveland
44121	Cleveland
44122	Beachwood
44125	Cleveland
44127	Cleveland
44128	Cleveland
44131	Independence
44137	Maple Heights

Table 9: Population Estimates for Each Zip Code

Zip code	City	Population
44102	Cleveland	41,976
44103	Cleveland	16,179
44104	Cleveland	21,988
44105	Cleveland	35,422
44106	Cleveland	26,538
44108	Cleveland	22,563
44109	Cleveland	37,153
44110	Cleveland	18,325
44112	Cleveland	20,733
44113	Cleveland	20,749
44114	Cleveland	6,822
44115	Cleveland	8,968
44117	Euclid	9,846
44118	Cleveland	38,730
44120	Cleveland	34,405
44121	Cleveland	31,150
44122	Beachwood	34,095
44125	Cleveland	26,717
44127	Cleveland	5,016
44128	Cleveland	27,367
44131	Independence	19,872
44137	Maple Heights	21,557

Table 10: Percentage of Families Living Below Poverty Level for Each Zip Code

Zip Code	City	Families Below Poverty Level (%)
44102	Cleveland	27.27%
44103	Cleveland	32.06%
44104	Cleveland	47.49%

44105	Cleveland	26.58%
44106	Cleveland	20.44%
44108	Cleveland	24.20%
44109	Cleveland	20.69%
44110	Cleveland	30.76%
44112	Cleveland	25.39%
44113	Cleveland	25.26%
44114	Cleveland	39.32%
44115	Cleveland	59.95%
44117	Euclid	10.60%
44118	Cleveland	7.76%
44120	Cleveland	16.37%
44121	Cleveland	10.80%
44122	Beachwood	4.75%
44125	Cleveland	10.28%
44127	Cleveland	40.80%
44128	Cleveland	19.54%
44131	Independence	2.61%
44137	Maple Heights	15.42%

Table 11: Secondary Data Results by Health Topic—Cuyahoga County

HEALTH TOPICS	CUYAHOGA
Alcohol & Drug Use	1.73
Cancer	1.71
Children's Health	1.72
Diabetes	1.17
Health Care Access & Quality	1.21
Heart Disease & Stroke	1.35
Immunizations & Infectious Diseases	1.20

Maternal, Fetal & Infant Health	1.56
Medications & Prescriptions	1.72
Mental Health & Mental Disorders	1.39
Nutrition & Healthy Eating	1.31
Older Adults	1.65
Oral Health	1.14
Other Conditions	1.83
Physical Activity	1.39
Prevention & Safety	2.21
Respiratory Diseases	1.23
Tobacco Use	1.19
Wellness & Lifestyle	1.49
Women's Health	1.46
QUALITY OF LIFE TOPIC	
Community	1.66
Economy	1.68
Education	1.55
Environmental Health	1.53

Secondary Data Scoring Indicators of Concern

From the secondary data scoring results, Health Care Access & Quality ranked as the 16th highest scoring health need, with a score of 1.21. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and are listed in Table 11. For each indicator, there is an indicator score, county value, state value, and national value (where available). Additionally, there are state and national county distributions for comparison along with indicator trend information. The legend (Figure 64) on the right shows how to interpret the distribution gauges and trend icons used in the data scoring results for each health topic by county (Table 12).

Figure 64: Prioritized Health Needs

	If the needle is in the red, the county value is in the worst 25% (or worst quartile) of counties in the state or nation.
	If the needle is in the green, the county value is in the best 50% of counties in the state or nation.
	The indicator is trending down, significantly, and this is not the ideal direction.
	The indicator is trending down and this is not the ideal direction.
	The indicator is trending up, significantly, and this is not the ideal direction.
	The indicator is trendng up and this is not the ideal direction.
	The indicator is trending down, signifcantly, and this is the ideal direction .
	The indicator is trending down and this is the ideal direction.
	The indicator is trending up, significantly, and this is the ideal direction.
	The indicator is trending up and this is the ideal direction.

Table 12. Data Scoring Results for Healthcare Access & Quality for the Cleveland Clinic Main Campus Community Cuyahoga County

SCORE	HEALTH CARE ACCESS & QUALITY	Cuyahoga County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
1.83	Adults with Health Insurance: 18+	89.8		90.2	90.6			---
1.83	Consumer Expenditures: Medical Services	1057.6		1098.6	1047.4			---
1.83	Consumer Expenditures: Medical Supplies	199.2		204.8	194.9			---
1.50	Adults who Visited a Dentist	51.3		51.6	52.9			---
1.50	Consumer Expenditures: Prescription and Non-Prescription Drugs	627.2		638.9	609.6			---

HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.

Table 13: Secondary Data Scoring Indicators of Concern: Prioritized Health Topic #2: Behavioral Health (Mental Health and Substance Misuse)

From the secondary data scoring results, Mental Health & Mental Disorders had the 11th highest data score of all topic areas, with a score of 1.39. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and are listed in Table 13 below. Cuyahoga County did not have any indicators under Mental Health & Mental Disorders with a data score above 1.5.

Cuyahoga County

SCORE	MENTAL HEALTH & MENTAL DISORDERS	CuyahogaCounty	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.17	Alzheimer's Disease or Dementia: Medicare Population	11.4		10.4	10.8			
1.83	Poor Mental Health: Average Number of Days	5		4.8	4.1			…
1.75	Depression: Medicare Population	18.5		20.4	18.4			
1.75	Poor Mental Health: 14+ Days	16			13.6			…
1.61	Age-Adjusted Death Rate due to Suicide	14	12.8	15.1	14.1			

HP2030 · Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.

Table 14: Secondary Data Scoring Indicators of Concern: Prioritized Health Topic #3: Chronic Disease Prevention & Management

Nutrition & Healthy Eating had the 14th highest data score of all topic areas with a score of 1.31. The Older Adult Health topic area had the seventh highest score at 1.65 and the related Other Conditions health topic ranked second with a score of 1.83. All topic areas in this group demonstrate need per as they each scored above 1.5. Further analysis was done to identify specific indicators of concern which include indicators with high data scores (scoring at or above the threshold of 1.50) and seen in Table 14.

Cuyahoga County

SCORE	CHRONIC DISEASE PREVENTION & MANAGEMENT	Cuyahoga County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.72	Age-Adjusted Death Rate due to Prostate Cancer	23.8	16.9	19.4	18.9			
2.58	Breast Cancer Incidence Rate	134.8		129.6	126.8			
2.36	Prostate Cancer Incidence Rate	128		107.2	106.2			
2.31	Cancer: Medicare Population	9		8.4	8.4			
2.28	Age-Adjusted Death Rate due to Breast Cancer	23.6	15.3	21.6	19.9			
2.25	All Cancer Incidence Rate	479.7		467.5	448.6			

2.14	Colorectal Cancer Incidence Rate	44.2		41.3	38			
1.78	Age-Adjusted Death Rate due to Cancer	171	122.7	169.4	152.4			
1.67	Colon Cancer Screening	63.7	74.4		66.4			...
1.67	Consumer Expenditures: Fruits and Vegetables	838.8		864.6	1002.1			...
1.50	Consumer Expenditures: High Sugar Foods	502.1		519	530.2			...
2.64	People 65+ Living Alone	34.8		28.8	26.1			
2.47	People 65+ Living Below Poverty Level	10.9		8.1	9.3			
2.31	Age-Adjusted Death Rate due to Falls	11.6		10.5	9.5			
2.17	Alzheimer's Disease or Dementia: Medicare Population	11.4		10.4	10.8			

2.14	Atrial Fibrillation: Medicare Population	9		9	8.4			
2.08	Osteoporosis: Medicare Population	6.3		6.2	6.6			...
2.03	Asthma: Medicare Population	5.2		4.8	5			
1.92	Chronic Kidney Disease: Medicare Population	25.2		25.3	24.5			
1.92	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	35.4		36.1	33.5			
1.75	Adults 65+ who Received Recommended Preventive Services: Females	28.6			28.4			...
1.75	Depression: Medicare Population	18.5		20.4	18.4			
1.69	Heart Failure: Medicare Population	15.3		14.7	14			
1.67	People 65+ with Low Access to a Grocery Store	3.4						...

1.58	Adults 65+ with Total Tooth Loss	15.5			13.5			---
1.92	Adults with Kidney Disease	3.6			3.1			---
1.69	Age-Adjusted Death Rate due to Kidney Disease	15.2		14.5	12.9			

HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.

Table 15: Secondary Data Scoring Indicators of Concern: Prioritized Health Topic #4: Maternal, Fetal & Infant Health

Among all health topics, Maternal, Fetal and Infant Health ranked eighth with a score of 1.56. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and are listed in Table 15 below. See Appendix C for the full list of indicators categorized within this topic.

Cuyahoga County

SCORE	MATERNAL, FETAL & INFANT HEALTH	Cuyahoga County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.11	Babies with Low Birth Weight	10.8		8.5	**8.2**		---	
2.11	Babies with Very Low Birth Weight	1.7		1.4	**1.3**		---	

1.78	Infant Mortality Rate	8.6	5	6.9		---	---	
1.67	Preterm Births	11.4	9.4	10.3			---	
1.58	Teen Pregnancy Rate	23.9		19.5			---	
1.53	Teen Birth Rate: 15-17	7.2		6.8			---	

HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.

Table 16: Secondary Data Scoring Indicators of Concern: Prioritized Health Topic #5: Socioeconomic Issues

Prevention & Safety ranked first among all health topics with a score of 2.21. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and are listed in Table 16 below. See Appendix C for the full list of indicators categorized within this topic.

Cuyahoga County

SCORE	PREVENTION & SAFETY	Cuyahoga County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.31	Age-Adjusted Death Rate due to Falls	11.6		10.5	9.5			
2.00	Age-Adjusted Death Rate due to Motor Vehicle Collisions	3.6		2.8	2.5	...	...	...

2.22	Age-Adjusted Death Rate due to Unintentional Injuries	69.7	43.2	68.8	48.9			
2.31	Age-Adjusted Death Rate due to Unintentional Poisonings	42		40.2	21.4			
2.64	Death Rate due to Drug Poisoning	42.6		38.1	21			

HP2030 · Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.

Table 17: Secondary Data Scoring Results by Health Topic for The Cleveland Clinic Main Campus Community in Rank Order by Topic Score

HEALTH TOPICS	AVG
Medications & Prescriptions	2.18
Other Conditions	1.84
Prevention & Safety	1.74
Alcohol & Drug Use	1.63
Older Adults	1.59
Cancer	1.54
Children's Health	1.52
Nutrition & Healthy Eating	1.51
Women's Health	1.50
Health Care Access & Quality	1.44
Physical Activity	1.43
Maternal, Fetal & Infant Health	1.43
Heart Disease & Stroke	1.41
Mental Health & Mental Disorders	1.40
Wellness & Lifestyle	1.34
Respiratory Diseases	1.20
Tobacco Use	1.17
Diabetes	1.13
Oral Health	1.13
Immunizations & Infectious Diseases	1.07

QUALITY OF LIFE TOPIC	SCORE
Education	1.49
Community	1.42
Environmental Health	1.37
Economy	1.25

SCORE	ALCOHOL & DRUG USE	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.64	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	42.6		38.1	21	*2017-2019*	9
2.44	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	41.4	28.3	32.2	27	*2015-2019*	9
2.00	Adults who Drink Excessively	*percent*	19.6		18.5	19	*2018*	9
1.92	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate	*Deaths per 100,000 population*	43.8		42	22.8	*2017-2019*	5
1.67	Consumer Expenditures: Alcoholic Beverages	*average dollar amount per consumer unit*	637.1		651.5	701.9	*2021*	7
1.42	Health Behaviors Ranking	*ranking*	31				*2021*	9

1.31	Liquor Store Density	*stores/ 100,000 population*	6.4		5.6	10.5	*2019*	22
1.25	Adults who Binge Drink	*percent*	16			16.7	*2019*	4
0.92	Mothers who Smoked During Pregnancy	*percent*	6.1	4.3	11.5	5.5	*2020*	17

SCORE	CANCER	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.72	Age-Adjusted Death Rate due to Prostate Cancer	*deaths/ 100,000 males*	23.8	16.9	19.4	18.9	*2015-2019*	12
2.58	Breast Cancer Incidence Rate	*cases/ 100,000 females*	134.8		129.6	126.8	*2014-2018*	12
2.36	Prostate Cancer Incidence Rate	*cases/ 100,000 males*	128		107.2	106.2	*2014-2018*	12
2.31	Cancer: Medicare Population	*percent*	9		8.4	8.4	*2018*	6
2.28	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	23.6	15.3	21.6	19.9	*2015-2019*	12
2.25	All Cancer Incidence Rate	*cases/ 100,000 population*	479.7		467.5	448.6	*2014-2018*	12
2.14	Colorectal Cancer Incidence Rate	*cases/ 100,000 population*	44.2		41.3	38	*2014-2018*	12

1.78	Age-Adjusted Death Rate due to Cancer	*deaths/ 100,000 population*	171	122.7	169.4	152.4	*2015-2019*	12
1.67	Colon Cancer Screening	*percent*	63.7	74.4		66.4	*2018*	4
1.44	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	42.9	25.1	45	36.7	*2015-2019*	12
1.36	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	63.7		67.3	57.3	*2014-2018*	12
1.28	Age-Adjusted Death Rate due to Colorectal Cancer	*deaths/ 100,000 population*	14.5	8.9	14.8	13.4	*2015-2019*	12
1.25	Adults with Cancer	*percent*	7.5			7.1	*2019*	4
1.14	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	11.5		12.2	11.9	*2014-2018*	12
0.94	Mammogram in Past 2 Years: 50-74	*percent*	75.2	77.1		74.8	*2018*	4
0.89	Cervical Cancer Screening: 21-65	*Percent*	85.3	84.3		84.7	*2018*	4
0.61	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	6.4		7.9	7.7	*2014-2018*	12

SCORE	CHILDREN'S HEALTH	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.17	Child Food Insecurity Rate	*percent*	20.7		17.4	14.6	*2019*	10
2.08	Projected Child Food Insecurity Rate	*percent*	23.4		18.5		*2021*	10
1.94	Substantiated Child Abuse Rate	*cases/ 1,000 children*	10	8.7	6.8		*2020*	3
1.86	Blood Lead Levels in Children (>=10 micrograms per deciliter)	*percent*	1.7		0.5		*2020*	19
1.58	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	5.8		1.9		*2020*	19
1.50	Children with Low Access to a Grocery Store	*percent*	4.3				*2015*	23
1.33	Children with Health Insurance	*percent*	97.1		95.2	94.3	*2019*	1
1.33	Consumer Expenditures: Childcare	*average dollar amount per consumer unit*	272.1		301.6	368.2	*2021*	7

SCORE	COMMUNITY	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.64	People 65+ Living Alone	*percent*	34.8		28.8	26.1	*2015-2019*	1
2.50	Single-Parent Households	*percent*	37.6		27.1	25.5	*2015-2019*	1
2.47	Homeownership	*percent*	50.9		59.4	56.2	*2015-2019*	1
2.44	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	41.4	28.3	32.2	27	*2015-2019*	9
2.39	Violent Crime Rate	*crimes/ 100,000 population*	637		303.5	394	*2017*	18
2.31	Social Associations	*membership associations/ 10,000 population*	9.2		11	9.3	*2018*	9
2.14	Linguistic Isolation	*percent*	2.9		1.4	4.4	*2015-2019*	1
2.08	Households without a Vehicle	*percent*	12.8		7.9	8.6	*2015-2019*	1
2.00	Age-Adjusted Death Rate due to Motor Vehicle Collisions	*deaths/ 100,000 population*	3.6		2.8	2.5	*2015-2019*	5
2.00	People Living Below Poverty Level	*percent*	17.5	8	14	13.4	*2015-2019*	1
1.94	Substantiated Child Abuse Rate	*cases/ 1,000 children*	10	8.7	6.8		*2020*	3

1.92	Children Living Below Poverty Level	*percent*	25.5		19.9	18.5	*2015-2019*	1
1.75	Median Household Income	*dollars*	50366		56602	62843	*2015-2019*	1
1.75	Social and Economic Factors Ranking	*ranking*	72				*2021*	9
1.75	Young Children Living Below Poverty Level	*percent*	27.3		23	20.3	*2015-2019*	1
1.75	Youth not in School or Working	*percent*	2.3		1.8	1.9	*2015-2019*	1
1.69	Voter Turnout: Presidential Election	*percent*	71		74		*2020*	20
1.67	Consumer Expenditures: Local Public Transportation	*average dollar amount per consumer unit*	122.3		121.7	148.8	*2021*	7
1.67	Households with an Internet Subscription	*percent*	79.1		82.4	83	*2015-2019*	1
1.67	Households with One or More Types of Computing Devices	*percent*	87.4		89.1	90.3	*2015-2019*	1
1.53	Mean Travel Time to Work	*minutes*	24.3		23.7	26.9	*2015-2019*	1

1.50	Adults with Internet Access	*percent*	94.3		94.5	95	*2021*	8
1.50	Households with a Computer	*percent*	84.2		85.2	86.3	*2021*	8
1.50	Persons with an Internet Subscription	*percent*	84		86.2	86.2	*2015-2019*	1
1.36	Solo Drivers with a Long Commute	*percent*	32.3		31.1	37	*2015-2019*	9
1.33	Households with a Smartphone	*percent*	80.3		80.5	81.9	*2021*	8
1.06	Workers Commuting by Public Transportation	*percent*	4.6	5.3	1.6	5	*2015-2019*	1
1.03	Workers who Drive Alone to Work	*percent*	79.3		82.9	76.3	*2015-2019*	1
1.00	Households with No Car and Low Access to a Grocery Store	*percent*	1.3				*2015*	23
0.83	Households with Wireless Phone Service	*percent*	97.2		96.8	97	*2020*	8
0.69	Workers who Walk to Work	*percent*	2.7		2.2	2.7	*2015-2019*	1
0.58	Per Capita Income	*dollars*	33114		31552	34103	*2015-2019*	1

0.25	People 25+ with a Bachelor's Degree or Higher	*percent*	32.5		28.3	32.1	*2015-2019*	1

SCORE	DIABETES	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
1.50	Adults 20+ with Diabetes	*percent*	9				*2019*	5
1.14	Diabetes: Medicare Population	*percent*	25.3		27.2	27	*2018*	6
0.86	Age-Adjusted Death Rate due to Diabetes	*deaths/ 100,000 population*	22.4		25.3	21.5	*2017-2019*	5

SCORE	ECONOMY	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.47	Homeownership	*percent*	50.9		59.4	56.2	*2015-2019*	1
2.47	People 65+ Living Below Poverty Level	*percent*	10.9		8.1	9.3	*2015-2019*	1
2.17	Child Food Insecurity Rate	*percent*	20.7		17.4	14.6	*2019*	10
2.17	Income Inequality		0.5		0.5	0.5	*2015-2019*	1
2.08	Persons with Disability Living in Poverty (5-year)	*percent*	33.9		29.5	26.1	*2015-2019*	1
2.08	Projected Child Food Insecurity Rate	*percent*	23.4		18.5		*2021*	10

2.00	Adults who Feel Overwhelmed by Financial Burdens	*percent*	15.1		14.6	14.4	*2021*	8
2.00	Food Insecurity Rate	*percent*	13.9		13.2	10.9	*2019*	10
2.00	Households that are Below the Federal Poverty Level	*percent*	17.7		13.8		*2018*	25
2.00	People Living Below Poverty Level	*percent*	17.5	8	14	13.4	*2015-2019*	1
1.92	Children Living Below Poverty Level	*percent*	25.5		19.9	18.5	*2015-2019*	1
1.92	Families Living Below Poverty Level	*percent*	13		9.9	9.5	*2015-2019*	1
1.92	Projected Food Insecurity Rate	*percent*	15.6		14.1		*2021*	10
1.83	Renters Spending 30% or More of Household Income on Rent	*percent*	48.4		44.9	49.6	*2015-2019*	1
1.75	Households with Cash Public Assistance Income	*percent*	3.1		2.9	2.4	*2015-2019*	1
1.75	Median Household Income	*dollars*	50366		56602	62843	*2015-2019*	1

1.75	Severe Housing Problems	*percent*	17.1		13.7	18	*2013-2017*	9
1.75	Social and Economic Factors Ranking	*ranking*	72				*2021*	9
1.75	Young Children Living Below Poverty Level	*percent*	27.3		23	20.3	*2015-2019*	1
1.75	Youth not in School or Working	*percent*	2.3		1.8	1.9	*2015-2019*	1
1.67	Households that are Above the Asset Limited, Income Constrained, Employed (ALICE) Threshold	*percent*	58.8		61.6		*2018*	25
1.64	Size of Labor Force	*persons*	582791				*Sep-21*	21
1.64	SNAP Certified Stores	*stores/ 1,000 population*	0.9				*2017*	23
1.50	Households with a Savings Account	*percent*	67.7		68.8	70.2	*2021*	8
1.50	WIC Certified Stores	*stores/ 1,000 population*	0.1				*2016*	23
1.42	People Living 200% Above Poverty Level	*percent*	64.7		68.8	69.1	*2015-2019*	1

1.33	Consumer Expenditures: Homeowner Expenses	*average dollar amount per consumer unit*	7600		7828	8900.1	*2021*	7
1.33	Households that are Asset Limited, Income Constrained, Employed (ALICE)	*percent*	23.5		24.5		*2018*	25
1.33	Low-Income and Low Access to a Grocery Store	*percent*	4.3				*2015*	23
1.31	Overcrowded Households	*percent of households*	1.2		1.4		*2015-2019*	1
1.25	Unemployed Workers in Civilian Labor Force	*percent*	4.6		4.3	4.6	*Sep-21*	21
1.17	Consumer Expenditures: Home Rental Expenses	*average dollar amount per consumer unit*	3928.7		3798.7	5460.2	*2021*	7
1.00	Mortgaged Owners Spending 30% or More of Household Income on Housing	*percent*	22.7		19.7	26.5	*2019*	1
0.58	Per Capita Income	*dollars*	33114		31552	34103	*2015-2019*	1

0.58	Students Eligible for the Free Lunch Program	*percent*	12.9				*2019-2020*	13

SCORE	EDUCATION	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
1.86	4th Grade Students Proficient in English/Language Arts	*percent*	46.6		63.3		*2018-2019*	15
1.86	4th Grade Students Proficient in Math	*percent*	52.5		74.3		*2018-2019*	15
1.86	8th Grade Students Proficient in English/Language Arts	*percent*	43.1		58.3		*2018-2019*	15
1.86	8th Grade Students Proficient in Math	*percent*	39.5		57.3		*2018-2019*	15
1.33	Consumer Expenditures: Childcare	*average dollar amount per consumer unit*	272.1		301.6	368.2	*2021*	7
1.67	Consumer Expenditures: Education	*average dollar amount per consumer unit*	1196.7		1200.4	1492.4	*2021*	7
1.44	High School Graduation	*percent*	89.5	90.7	92		*2019-2020*	15

0.25	People 25+ with a Bachelor's Degree or Higher	*percent*	32.5		28.3	32.1	*2015-2019*	1
1.81	Student-to-Teacher Ratio	*students/ teacher*	16.5				*2019-2020*	13

SCORE	ENVIRONMENTAL HEALTH	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.25	Adults with Current Asthma	*percent*	11			8.9	*2019*	4
2.14	Fast Food Restaurant Density	*restaurants/ 1,000 population*	0.9				*2016*	23
2.08	Houses Built Prior to 1950	*percent*	39.2		26.2	17.5	*2015-2019*	1
2.03	Asthma: Medicare Population	*percent*	5.2		4.8	5	*2018*	6
1.86	Blood Lead Levels in Children (>=10 micrograms per deciliter)	*percent*	1.7		0.5		*2020*	19
1.75	Annual Ozone Air Quality		F				*2017-2019*	2
1.75	Physical Environment Ranking	*ranking*	88				*2021*	9
1.75	Severe Housing Problems	*percent*	17.1		13.7	18	*2013-2017*	9

1.67	Farmers Market Density	*markets/ 1,000 population*	0				*2018*	23
1.67	People 65+ with Low Access to a Grocery Store	*percent*	3.4				*2015*	23
1.64	Number of Extreme Precipitation Days	*days*	34				*2019*	14
1.64	SNAP Certified Stores	*stores/ 1,000 population*	0.9				*2017*	23
1.58	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	5.8		1.9		*2020*	19
1.53	Food Environment Index	*index*	7.3		6.8	7.8	*2021*	9
1.50	Children with Low Access to a Grocery Store	*percent*	4.3				*2015*	23
1.50	WIC Certified Stores	*stores/ 1,000 population*	0.1				*2016*	23
1.44	Annual Particle Pollution		B				*2017-2019*	2
1.36	Number of Extreme Heat Days	*days*	12				*2019*	14
1.36	Number of Extreme Heat Events	*events*	6				*2019*	14

1.36	Weeks of Moderate Drought or Worse	*weeks per year*	0				*2020*	14
1.33	Low-Income and Low Access to a Grocery Store	*percent*	4.3				*2015*	23
1.31	Grocery Store Density	*stores/ 1,000 population*	0.2				*2016*	23
1.31	Liquor Store Density	*stores/ 100,000 population*	6.4		5.6	10.5	*2019*	22
1.31	Overcrowded Households	*percent of households*	1.2		1.4		*2015-2019*	1
1.08	PBT Released	*pounds*	234591.7				*2020*	24
1.00	Households with No Car and Low Access to a Grocery Store	*percent*	1.3				*2015*	23
1.00	Recreation and Fitness Facilities	*facilities/ 1,000 population*	0.1				*2016*	23
0.50	Access to Exercise Opportunities	*percent*	97.5		83.9	84	*2020*	9

SCORE	HEALTH CARE ACCESS & QUALITY	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
1.83	Adults with Health Insurance: 18+	*percent*	89.8		90.2	90.6	*2021*	8
1.83	Consumer Expenditures: Medical Services	*average dollar amount per consumer unit*	1057.6		1098.6	1047.4	*2021*	7
1.83	Consumer Expenditures: Medical Supplies	*average dollar amount per consumer unit*	199.2		204.8	194.9	*2021*	7
1.50	Adults who Visited a Dentist	*percent*	51.3		51.6	52.9	*2021*	8
1.50	Consumer Expenditures: Prescription and Non-Prescription Drugs	*average dollar amount per consumer unit*	627.2		638.9	609.6	*2021*	7
1.42	Adults without Health Insurance	*percent*	13			13	*2019*	4
1.39	Persons without Health Insurance	*percent*	5.3		6.6		*2019*	1
1.33	Adults with Health Insurance	*percent*	92.2		90.9	87.1	*2019*	1
1.33	Children with Health Insurance	*percent*	97.1		95.2	94.3	*2019*	1

1.33	Consumer Expenditures: Health Insurance	*average dollar amount per consumer unit*	4238.3		4371.7	4321.1	*2021*	7
1.25	Adults who have had a Routine Checkup	*percent*	78.2			76.6	*2019*	4
1.25	Clinical Care Ranking		10				*2021*	9
0.61	Primary Care Provider Rate	*providers/ 100,000 population*	112.7		76.7		*2018*	9
0.33	Dentist Rate	*dentists/ 100,000 population*	109.6		64.2		*2019*	9
0.33	Mental Health Provider Rate	*providers/ 100,000 population*	401.4		261.3		*2020*	9
0.33	Non-Physician Primary Care Provider Rate	*providers/ 100,000 population*	180.6		108.9		*2020*	9

SCORE	HEART DISEASE & STROKE	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.14	Atrial Fibrillation: Medicare Population	*percent*	9		9	8.4	*2018*	6
1.92	Adults who Experienced a Stroke	*percent*	4.2			3.4	*2019*	4
1.69	Heart Failure: Medicare Population	*percent*	15.3		14.7	14	*2018*	6
1.50	Age-Adjusted Death Rate due to Coronary Heart Disease	*deaths/ 100,000 population*	107.8	71.1	101.4	90.5	*2017-2019*	5
1.50	High Blood Pressure Prevalence	*percent*	35.4	27.7		32.6	*2019*	4
1.44	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	*deaths/ 100,000 population*	36.6	33.4	42.5	37.2	*2017-2019*	5
1.42	Adults who Experienced Coronary Heart Disease	*percent*	7.4			6.2	*2019*	4
1.36	Stroke: Medicare Population	*percent*	3.8		3.8	3.8	*2018*	6

1.31	Hypertension: Medicare Population	*percent*	57.2		59.5	57.2	*2018*	6
1.25	Adults who Have Taken Medications for High Blood Pressure	*percent*	78.7			76.2	*2019*	4
1.25	Cholesterol Test History	*percent*	86.3			87.6	*2019*	4
1.00	Hyperlipidemia: Medicare Population	*percent*	45.2		49.4	47.7	*2018*	6
1.00	Ischemic Heart Disease: Medicare Population	*percent*	25.8		27.5	26.8	*2018*	6
0.92	High Cholesterol Prevalence: Adults 18+	*percent*	32.2			33.6	*2019*	4
0.58	Age-Adjusted Death Rate due to Heart Attack	*deaths/ 100,000 population 35+ years*	42.3		55.4		*2019*	14

SCORE	IMMUNIZATIONS & INFECTIOUS DISEASES	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.39	Chlamydia Incidence Rate	*cases/ 100,000 population*	949.5		561.9	551	*2019*	16
2.39	Gonorrhea Incidence Rate	*cases/ 100,000 population*	432.9		224	187.8	*2019*	16
1.61	Tuberculosis Incidence Rate	*cases/ 100,000 population*	1.2	1.4	1.1		*2020*	16
1.53	COVID-19 Daily Average Case-Fatality Rate	*deaths per 100 cases*	0		0	0.5	*28-Jan-22*	11
1.31	Overcrowded Households	*percent of households*	1.2		1.4		*2015-2019*	1
1.17	Adults who Agree Vaccine Benefits Outweigh Possible Risks	*Percent*	48.6		48.6	49.4	*2021*	8
0.83	Salmonella Infection Incidence Rate	*cases/ 100,000 population*	10	11.1	12.9		*2018*	16
0.58	Persons Fully Vaccinated Against COVID-19	*percent*	62.8				*28-Jan-22*	5
0.08	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	11.1		14.4	13.8	*2017-2019*	5

0.08	COVID-19 Daily Average Incidence Rate	*cases per 100,000 population*	30.6		128.4	177.3	*28-Jan-22*	11

SCORE	MATERNAL, FETAL & INFANT HEALTH	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.11	Babies with Low Birth Weight	*percent*	10.8		8.5	8.2	*2020*	17
2.11	Babies with Very Low Birth Weight	*percent*	1.7		1.4	1.3	*2020*	17
1.33	Consumer Expenditures: Childcare	*average dollar amount per consumer unit*	272.1		301.6	368.2	*2021*	7
1.78	Infant Mortality Rate	*deaths/ 1,000 live births*	8.6	5	6.9		*2019*	17
1.00	Mothers who Received Early Prenatal Care	*percent*	72.4		68.9	76.1	*2020*	17
0.92	Mothers who Smoked During Pregnancy	*percent*	6.1	4.3	11.5	5.5	*2020*	17
1.67	Preterm Births	*percent*	11.4	9.4	10.3		*2020*	17
1.53	Teen Birth Rate: 15-17	*live births/ 1,000 females aged 15-17*	7.2		6.8		*2020*	17
1.58	Teen Pregnancy Rate	*pregnancies/ 1,000*	23.9		19.5		*2016*	17

		females aged 15-17						

SCORE	MEDICATIONS & PRESCRIPTIONS	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
1.83	Consumer Expenditures: Medical Services	*average dollar amount per consumer unit*	1057.6		1098.6	1047.4	*2021*	7
1.83	Consumer Expenditures: Medical Supplies	*average dollar amount per consumer unit*	199.2		204.8	194.9	*2021*	7
1.50	Consumer Expenditures: Prescription and Non-Prescription Drugs	*average dollar amount per consumer unit*	627.2		638.9	609.6	*2021*	7

SCORE	MENTAL HEALTH & MENTAL DISORDERS	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
1.42	Adults Ever Diagnosed with Depression	*percent*	20.9			18.8	*2019*	4
0.64	Age-Adjusted Death Rate due to Alzheimer's Disease	*deaths/ 100,000 population*	21		34	30.5	*2017-2019*	5

1.61	Age-Adjusted Death Rate due to Suicide	*deaths/ 100,000 population*	14	12.8	15.1	14.1	*2017-2019*	5
2.17	Alzheimer's Disease or Dementia: Medicare Population	*percent*	11.4		10.4	10.8	*2018*	6
1.75	Depression: Medicare Population	*percent*	18.5		20.4	18.4	*2018*	6
0.33	Mental Health Provider Rate	*providers/ 100,000 population*	401.4		261.3		*2020*	9
1.75	Poor Mental Health: 14+ Days	*percent*	16			13.6	*2019*	4
1.83	Poor Mental Health: Average Number of Days	*days*	5		4.8	4.1	*2018*	9
1.00	Self-Reported General Health Assessment: Good or Better	*percent*	85.8		85.6	86.5	*2021*	8

SCORE	NUTRITION & HEALTHY EATING	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
1.67	Consumer Expenditures: Fruits and Vegetables	*average dollar amount per consumer unit*	838.8		864.6	1002.1	*2021*	7
1.50	Consumer Expenditures: High Sugar Foods	*average dollar amount per consumer unit*	502.1		519	530.2	*2021*	7
1.33	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	*Percent*	41.1		41.5	41.2	*2021*	8
1.33	Consumer Expenditures: Fast Food Restaurants	*average dollar amount per consumer unit*	1415.1		1461	1638.9	*2021*	7
1.17	Consumer Expenditures: High Sugar Beverages	*average dollar amount per consumer unit*	310.6		319.7	357	*2021*	7
0.83	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	*percent*	79.6		80.9	80.4	*2021*	8

SCORE	OLDER ADULT HEALTH	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.64	People 65+ Living Alone	*percent*	34.8		28.8	26.1	*2015-2019*	1
2.47	People 65+ Living Below Poverty Level	*percent*	10.9		8.1	9.3	*2015-2019*	1
2.31	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	11.6		10.5	9.5	*2017-2019*	5
2.31	Cancer: Medicare Population	*percent*	9		8.4	8.4	*2018*	6
2.17	Alzheimer's Disease or Dementia: Medicare Population	*percent*	11.4		10.4	10.8	*2018*	6
2.14	Atrial Fibrillation: Medicare Population	*percent*	9		9	8.4	*2018*	6
2.08	Osteoporosis: Medicare Population	*percent*	6.3		6.2	6.6	*2018*	6
2.03	Asthma: Medicare Population	*percent*	5.2		4.8	5	*2018*	6
1.92	Chronic Kidney Disease: Medicare Population	*percent*	25.2		25.3	24.5	*2018*	6

1.92	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	35.4		36.1	33.5	*2018*	6
1.75	Adults 65+ who Received Recommended Preventive Services: Females	*percent*	28.6			28.4	*2018*	4
1.75	Depression: Medicare Population	*percent*	18.5		20.4	18.4	*2018*	6
1.69	Heart Failure: Medicare Population	*percent*	15.3		14.7	14	*2018*	6
1.67	Colon Cancer Screening	*percent*	63.7	74.4		66.4	*2018*	4
1.67	People 65+ with Low Access to a Grocery Store	*percent*	3.4				*2015*	23
1.58	Adults 65+ with Total Tooth Loss	*percent*	15.5			13.5	*2018*	4
1.42	Adults with Arthritis	*percent*	29.3			25.1	*2019*	4
1.36	Stroke: Medicare Population	*percent*	3.8		3.8	3.8	*2018*	6

1.31	Hypertension: Medicare Population	*percent*	57.2		59.5	57.2	*2018*	6
1.14	Diabetes: Medicare Population	*percent*	25.3		27.2	27	*2018*	6
1.00	Consumer Expenditures: Eldercare	*average dollar amount per consumer unit*	20.8		20.5	34.3	*2021*	7
1.00	Hyperlipidemia: Medicare Population	*percent*	45.2		49.4	47.7	*2018*	6
1.00	Ischemic Heart Disease: Medicare Population	*percent*	25.8		27.5	26.8	*2018*	6
0.97	COPD: Medicare Population	*percent*	11.2		13.2	11.5	*2018*	6
0.92	Adults 65+ who Received Recommended Preventive Services: Males	*percent*	34.5			32.4	*2018*	4
0.64	Age-Adjusted Death Rate due to Alzheimer's Disease	*deaths/ 100,000 population*	21		34	30.5	*2017-2019*	5

SCORE	ORAL HEALTH	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
1.58	Adults 65+ with Total Tooth Loss	*percent*	15.5			13.5	*2018*	4
1.50	Adults who Visited a Dentist	*percent*	51.3		51.6	52.9	*2021*	8
1.14	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	11.5		12.2	11.9	*2014-2018*	12
0.33	Dentist Rate	*dentists/ 100,000 population*	109.6		64.2		*2019*	9

SCORE	OTHER CONDITIONS	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.08	Osteoporosis: Medicare Population	*percent*	6.3		6.2	6.6	*2018*	6
1.92	Adults with Kidney Disease	*Percent of adults*	3.6			3.1	*2019*	4
1.92	Chronic Kidney Disease: Medicare Population	*percent*	25.2		25.3	24.5	*2018*	6
1.92	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	35.4		36.1	33.5	*2018*	6

1.69	Age-Adjusted Death Rate due to Kidney Disease	*deaths/ 100,000 population*	15.2		14.5	12.9	*2017-2019*	5
1.42	Adults with Arthritis	*percent*	29.3			25.1	*2019*	4

SCORE	PHYSICAL ACTIVITY	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.22	Adults 20+ who are Obese	*percent*	34.2	36			*2019*	5
2.14	Fast Food Restaurant Density	*restaurants/ 1,000 population*	0.9				*2016*	23
1.67	Farmers Market Density	*markets/ 1,000 population*	0				*2018*	23
1.67	People 65+ with Low Access to a Grocery Store	*percent*	3.4				*2015*	23
1.64	Adults 20+ who are Sedentary	*percent*	25.1				*2019*	5
1.64	SNAP Certified Stores	*stores/ 1,000 population*	0.9				*2017*	23
1.53	Food Environment Index	*index*	7.3		6.8	7.8	*2021*	9
1.50	Children with Low Access to a Grocery Store	*percent*	4.3				*2015*	23

1.50	WIC Certified Stores	*stores/ 1,000 population*	0.1				*2016*	23
1.42	Health Behaviors Ranking	*ranking*	31				*2021*	9
1.33	Low-Income and Low Access to a Grocery Store	*percent*	4.3				*2015*	23
1.31	Grocery Store Density	*stores/ 1,000 population*	0.2				*2016*	23
1.00	Households with No Car and Low Access to a Grocery Store	*percent*	1.3				*2015*	23
1.00	Recreation and Fitness Facilities	*facilities/ 1,000 population*	0.1				*2016*	23
0.83	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	*percent*	79.6		80.9	80.4	*2021*	8
0.69	Workers who Walk to Work	*percent*	2.7		2.2	2.7	*2015-2019*	1
0.50	Access to Exercise Opportunities	*percent*	97.5		83.9	84	*2020*	9

SCORE	PREVENTION & SAFETY	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.31	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	11.6		10.5	9.5	*2017-2019*	5
2.00	Age-Adjusted Death Rate due to Motor Vehicle Collisions	*deaths/ 100,000 population*	3.6		2.8	2.5	*2015-2019*	5
2.22	Age-Adjusted Death Rate due to Unintentional Injuries	*deaths/ 100,000 population*	69.7	43.2	68.8	48.9	*2017-2019*	5
2.31	Age-Adjusted Death Rate due to Unintentional Poisonings	*deaths/ 100,000 population*	42		40.2	21.4	*2017-2019*	5
2.64	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	42.6		38.1	21	*2017-2019*	9
1.75	Severe Housing Problems	*percent*	17.1		13.7	18	*2013-2017*	9

SCORE	RESPIRATORY DISEASES	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.25	Adults with Current Asthma	*percent*	11			8.9	*2019*	4
2.03	Asthma: Medicare Population	*percent*	5.2		4.8	5	*2018*	6
2.00	Consumer Expenditures: Tobacco and Legal Marijuana	*average dollar amount per consumer unit*	485.5		487.9	422.4	*2021*	7
1.61	Tuberculosis Incidence Rate	*cases/ 100,000 population*	1.2	1.4	1.1		*2020*	16
1.58	Adults with COPD	*Percent of adults*	8.6			6.6	*2019*	4
1.53	COVID-19 Daily Average Case-Fatality Rate	*deaths per 100 cases*	0		0	0.5	*28-Jan-22*	11
1.44	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	42.9	25.1	45	36.7	*2015-2019*	12
1.42	Adults who Smoke	*percent*	20.9	5	21.4	17	*2018*	9
1.36	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	63.7		67.3	57.3	*2014-2018*	12
0.97	COPD: Medicare Population	*percent*	11.2		13.2	11.5	*2018*	6

0.83	Adults Who Used Electronic Cigarettes: Past 30 Days	*percent*	4		4.3	4.1	*2021*	8
0.81	Age-Adjusted Death Rate due to Chronic Lower Respiratory Diseases	*deaths/ 100,000 population*	38.4		47.8	39.6	*2017-2019*	5
0.50	Adults Who Used Smokeless Tobacco: Past 30 Days	*percent*	1.2		2.2	2	*2021*	8
0.08	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	11.1		14.4	13.8	*2017-2019*	5
0.08	COVID-19 Daily Average Incidence Rate	*cases per 100,000 population*	30.6		128.4	177.3	*28-Jan-22*	11

SCORE	TOBACCO USE	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.00	Consumer Expenditures: Tobacco and Legal Marijuana	*average dollar amount per consumer unit*	485.5		487.9	422.4	*2021*	7
1.42	Adults who Smoke	*percent*	20.9	5	21.4	17	*2018*	9
0.83	Adults Who Used Electronic Cigarettes: Past 30 Days	*percent*	4		4.3	4.1	*2021*	8
0.50	Adults Who Used Smokeless Tobacco: Past 30 Days	*percent*	1.2		2.2	2	*2021*	8

SCORE	WELLNESS & LIFESTYLE	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.58	Insufficient Sleep	*percent*	44.9	31.4	40.6	35	*2018*	9
1.75	Morbidity Ranking	*ranking*	76				*2021*	9
1.67	Poor Physical Health: Average Number of Days	*days*	4.2		4.1	3.7	*2018*	9
1.58	Poor Physical Health: 14+ Days	*percent*	14.3			12.5	*2019*	4
1.58	Self-Reported General Health Assessment: Poor or Fair	*percent*	21.1			18.6	*2019*	4

1.50	High Blood Pressure Prevalence	*percent*	35.4	27.7		32.6	*2019*	4
1.50	Life Expectancy	*years*	77		77	79.2	*2017-2019*	9
1.33	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	*Percent*	41.1		41.5	41.2	*2021*	8
1.33	Consumer Expenditures: Fast Food Restaurants	*average dollar amount per consumer unit*	1415.1		1461	1638.9	*2021*	7
1.17	Adults who Agree Vaccine Benefits Outweigh Possible Risks	*Percent*	48.6		48.6	49.4	*2021*	8
1.00	Self-Reported General Health Assessment: Good or Better	*percent*	85.8		85.6	86.5	*2021*	8
0.83	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	*percent*	79.6		80.9	80.4	*2021*	8

SCORE	WOMEN'S HEALTH	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.58	Breast Cancer Incidence Rate	*cases/ 100,000 females*	134.8		129.6	126.8	*2014-2018*	12
2.28	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	23.6	15.3	21.6	19.9	*2015-2019*	12
0.94	Mammogram in Past 2 Years: 50-74	*percent*	75.2	77.1		74.8	*2018*	4
0.89	Cervical Cancer Screening: 21-65	*Percent*	85.3	84.3		84.7	*2018*	4
0.61	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	6.4		7.9	7.7	*2014-2018*	12

Cuyahoga Data Sources

Key	Source Name
1	American Community Survey
2	American Lung Association
3	Annie E. Casey Foundation
4	CDC - PLACES
5	Centers for Disease Control and Prevention
6	Centers for Medicare & Medicaid Services
7	Claritas Consumer Buying Power
8	Claritas Consumer Profiles
9	County Health Rankings
10	Feeding America
11	Healthy Communities Institute

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 U.S. Bureau of Labor Statistics
22 U.S. Census - County Business Patterns
23 U.S. Department of Agriculture - Food Environment Atlas
24 U.S. Environmental Protection Agency
25 United For ALICE

Secondary Data Scoring Tables for Cleveland Clinic Children's Community

Table 18: The Cleveland Clinic Children's Community Definition

Zip code	Postal Name
44011	Avon
44012	Avon lake
44035	Elyria
44039	North Ridgeville
44050	Lagrange
44052	Lorain
44053	Lorain
44060	Mentor
44070	Noeth Olmsted
44077	Painesville
44087	Twinsburg
44090	Wellington
44102	Cleveland
44103	Cleveland
44104	Cleveland
44105	Cleveland
44106	Cleveland
44107	Lakewood
44108	Cleveland
44109	Cleveland
44110	Cleveland
44111	Cleveland
44112	Cleveland
44113	Cleveland
44117	Euclid
44118	Cleveland
44119	Cleveland

44120	Cleveland
44121	Cleveland
44122	Beachwood
44123	Euclid
44124	Cleveland
44125	Cleveland
44128	Cleveland
44129	Cleveland
44130	Cleveland
44131	Independence
44132	Euclid
44134	Cleveland
44135	Cleveland
44137	Maple Heights
44139	Solon
44140	Bay Village
44143	Highland Heights
44144	Cleveland
44146	Bedford
44212	Brunswick
44215	Chippewa Lake
44221	Cuyahoga Falls
44224	Stow
44233	Hinckley
44235	Homerville
44253	Litchfield
44254	Lodi
44256	Medina
44280	Valley City
44281	Wadsworth

44287	West Salem
44305	Akron
44306	Akron
44307	Akron
44310	Akron
44312	Akron
44313	Akron
44314	Akron
44320	Akron
44321	Akron
44333	Akron
44606	Apple Creek
44685	Uniontown
44691	Wooster

Table 19: Population <18 Estimates for Each Zip Code

Zip code	Population <18 years
44011	6901
44012	5525
44035	14284
44039	8085
44050	1235
44052	7534
44053	4316
44060	10323
44070	5787
44077	13438
44087	4958
44090	2196
44102	10984
44103	3462

44104	7611
44105	8750
44106	4409
44107	9601
44108	5418
44109	8964
44110	4356
44111	8378
44112	4470
44113	3604
44117	1583
44118	9205
44119	2168
44120	7673
44121	6500
44122	6179
44123	3532
44124	6782
44125	5658
44128	5741
44129	5592
44130	8617
44131	3141
44132	3294
44134	7226
44135	5939
44137	4548
44139	4610
44140	3250
44143	3847

44144	3742
44146	5195
44212	9862
44215	387
44221	5803
44224	7676
44233	1536
44235	499
44253	561
44254	869
44256	15033
44280	928
44281	6969
44287	1881
44305	5176
44306	6491
44307	2204
44310	5369
44312	5915
44313	4827
44314	4023
44320	3945
44321	3793
44333	3004
44606	3285
44685	6355
44691	9358

Table 20: Percentage of Families with Children Living Below Poverty Level for Each Zip Code

Zip code	Families with Children Living Below Poverty Level %
44011	2.3%
44012	1.7%
44035	14.2%
44039	2.2%
44050	2.8%
44052	22.1%
44053	8.1%
44060	2.7%
44070	4.7%
44077	5.4%
44087	4.3%
44090	2.3%
44102	21.9%
44103	24.3%
44104	41.0%
44105	20.9%
44106	16.5%
44107	6.6%
44108	18.9%
44109	16.7%
44110	20.1%
44111	11.9%
44112	19.0%
44113	19.4%
44117	7.7%
44118	6.1%
44119	10.9%
44120	11.8%
44121	8.1%

44122	3.5%
44123	13.1%
44124	2.0%
44125	8.8%
44128	14.0%
44129	4.5%
44130	4.4%
44131	0.8%
44132	14.6%
44134	3.7%
44135	17.3%
44137	12.6%
44139	2.7%
44140	1.2%
44143	3.0%
44144	7.9%
44146	5.5%
44212	3.3%
44215	5.2%
44221	5.9%
44224	4.2%
44233	2.0%
44235	5.8%
44253	0.4%
44254	4.6%
44256	3.4%
44280	0.7%
44281	3.2%
44287	6.1%
44305	14.4%

44306	25.1%
44307	33.7%
44310	18.8%
44312	4.6%
44313	5.6%
44314	11.4%
44320	15.7%
44321	1.8%
44333	2.2%
44606	6.5%
44685	4.4%
44691	4.2%

Table 21: Secondary Data Results by Health Topic—Cuyahoga, Lake, Lorain, Medina, Summit, and Wayne County

HEALTH TOPICS	CUYAHOGA	LAKE	LORAIN	MEDINA	SUMMIT	WAYNE
Children's Health	1.72	1.21	1.48	1.34	1.41	1.78
Maternal, Fetal & Infant Health	1.56	1.06	1.69	1.03	1.63	1.45
Quality of Life Topic						
Education	1.55	1.55	1.71	1.22	1.54	1.24

Table 22: Data Scoring Results for Children's Health for Cleveland Clinic Children's Cuyahoga County

SCORE	CHILDREN'S HEALTH	Cuyahoga County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.17	Child Food Insecurity Rate	20.7		17.4	14.6			...
2.08	Projected Child Food Insecurity Rate	23.4		18.5				...
1.94	Substantiated Child Abuse Rate	10	8.7	6.8			...	
1.86	Blood Lead Levels in Children (>=10 micrograms per deciliter)	1.7		0.5			...	
1.58	Blood Lead Levels in Children (>=5 micrograms per deciliter)	5.8		1.9			...	
1.50	Children with Low Access to a Grocery Store	4.3						...

HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.

Lake County

SCORE	CHILDREN'S HEALTH	Lake County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.00	Children with Low Access to a Grocery Store	8						...
1.83	Consumer Expenditures: Childcare	315		301.6	368.2			...

HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.

Lorain County

SCORE	CHILDREN'S HEALTH	Lorain County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.17	Consumer Expenditures: Childcare	336.9		301.6	368.2			...
1.83	Children with Low Access to a Grocery Store	6.7						...
1.56	Substantiated Child Abuse Rate	7.1	8.7	6.8			...	
1.50	Child Food Insecurity Rate	17.1		17.4	14.6			...

HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.

Medina County

SCORE	CHILDREN'S HEALTH	Medina County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.33	Consumer Expenditures: Childcare	403.8		301.6	368.2			...
1.83	Children with Low Access to a Grocery Store	6.8						...
1.72	Substantiated Child Abuse Rate	7.4	8.7	6.8			...	

HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.

Summit County

SCORE	CHILDREN'S HEALTH	Summit County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.00	Children with Low Access to a Grocery Store	7.2						...
1.83	Consumer Expenditures: Childcare	307		301.6	368.2			...

1.75	Projected Child Food Insecurity Rate	19.1		18.5				...
1.50	Child Food Insecurity Rate	17.4		17.4	14.6			...

HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.

Wayne County

SCORE	CHILDREN'S HEALTH	Wayne County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.00	Children with Health Insurance	75.8		95.2	94.3	...	...	...
1.61	Substantiated Child Abuse Rate	7.6	8.7	6.8			...	

HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.

Table 23: Data Scoring Results for Maternal, Fetal & Infant for Cleveland Clinic Children's

Cuyahoga County

SCORE	MATERNAL, FETAL & INFANT HEALTH	Cuyahoga County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.11	Babies with Low Birth Weight	10.8		8.5	8.2		...	
2.11	Babies with Very Low Birth Weight	1.7		1.4	1.3		...	
1.78	Infant Mortality Rate	8.6	5	6.9		...	...	
1.67	Preterm Births	11.4	9.4	10.3			...	
1.58	Teen Pregnancy Rate	23.9		19.5			...	
1.53	Teen Birth Rate: 15-17	7.2		6.8			...	

HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.

Lake County

SCORE	MATERNAL, FETAL & INFANT HEALTH	Lake County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend

1.83	Consumer Expenditures: Childcare	315		301.6	368.2			...

HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.

Lorain County

SCORE	MATERNAL, FETAL & INFANT HEALTH	Lorain County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.17	Consumer Expenditures: Childcare	336.9		301.6	368.2			...
2.06	Babies with Very Low Birth Weight	1.5		1.4	1.3		...	
2.06	Mothers who Received Early Prenatal Care	67		68.9	76.1		...	
1.89	Preterm Births	10.5	9.4	10.3			...	
1.75	Babies with Low Birth Weight	9		8.5	8.2		...	
1.53	Teen Birth Rate: 15-17	6.9		6.8			...	

HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.

Medina County

SCORE	MATERNAL, FETAL & INFANT HEALTH	Medina County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.33	Consumer Expenditures: Childcare	403.8		301.6	368.2			...

HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.

Summit County

SCORE	MATERNAL, FETAL & INFANT HEALTH	Summit County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.67	Babies with Low Birth Weight	9.4		8.5	8.2		...	...
2.39	Babies with Very Low Birth Weight	1.7		1.4	1.3		...	...
1.97	Teen Birth Rate: 15-17	8		6.8			...	
1.83	Consumer Expenditures: Childcare	307		301.6	368.2			...
1.50	Preterm Births	9.9	9.4	10.3			...	

HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.

Wayne County

SCORE	MATERNAL, FETAL & INFANT HEALTH	Wayne County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.50	Infant Mortality Rate	9	5	6.9		...	...	
2.39	Mothers who Received Early Prenatal Care	57.2		68.9	76.1		...	

HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.

Table 24: Data Scoring Results for Education for Cleveland Clinic Children's

Cuyahoga County

SCORE	EDUCATION	Cuyahoga County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
1.86	4th Grade Students Proficient in English/Language Arts	46.6		63.3			...	
1.86	4th Grade Students Proficient in Math	52.5		74.3			...	
1.86	8th Grade Students Proficient in English/Language Arts	43.1		58.3			...	
1.86	8th Grade Students Proficient in Math	39.5		57.3			...	

HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.

Lake County

SCORE	EDUCATION	Lake County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.14	8th Grade Students Proficient in Math	26.8		57.3			...	

2.00	8th Grade Students Proficient in English/Language Arts	21.7		58.3			...	...
1.86	Student-to-Teacher Ratio	18.5						
1.83	Consumer Expenditures: Childcare	315		301.6	368.2			...
1.83	Consumer Expenditures: Education	1212.2		1200.4	1492.4			...

HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.

Lorain County

SCORE	EDUCATION	Lorain County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.17	Consumer Expenditures: Childcare	336.9		301.6	368.2			...
1.97	4th Grade Students Proficient in Math	55.6		59.4			...	
1.83	Consumer Expenditures: Education	1217.2		1200.4	1492.4			...

1.81	4th Grade Students Proficient in English/Language Arts	55.3		56			...	
1.69	Student-to-Teacher Ratio	17.1						
1.67	8th Grade Students Proficient in Math	39.8		42.6			...	
1.50	8th Grade Students Proficient in English/Language Arts	53.5		52.7			...	
1.50	High School Graduation	91.5	90.7	92			...	

HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.

Medina County

SCORE	EDUCATION	Medina County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.33	Consumer Expenditures: Childcare	403.8		301.6	368.2			...
2.17	Consumer Expenditures: Education	1490.7		1200.4	1492.4			...

1.58	Student-to-Teacher Ratio	18.3						
1.50	8th Grade Students Proficient in Math	62.1		57.3			...	

HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.

Summit County

SCORE	EDUCATION	Summit County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
1.86	4th Grade Students Proficient in English/Language Arts	56.5		63.3			...	
1.83	Consumer Expenditures: Childcare	307		301.6	368.2			...
1.83	Consumer Expenditures: Education	1208.5		1200.4	1492.4			...
1.81	Student-to-Teacher Ratio	16.8						
1.69	4th Grade Students Proficient in Math	67.4		74.3			...	

1.58	8th Grade Students Proficient in English/Language Arts	51.1		58.3			...	
1.58	8th Grade Students Proficient in Math	48.7		57.3			...	

HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.

Wayne County

SCORE	EDUCATION	Wayne County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
1.69	People 25+ with a Bachelor's Degree or Higher	22.2		28.3	32.1			
1.53	Student-to-Teacher Ratio	16.2						

HP2030 - Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. HP2030 represents a Healthy People target to be met by 2030.

Table 25: Health Topics included in Secondary Data Analysis for the Cleveland Clinic Children's Community by Topic Score

HEALTH TOPICS
Children's Health
Education
Maternal, Fetal & Infant Health

Cuyahoga County

SCORE	CHILDREN'S HEALTH	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.17	Child Food Insecurity Rate	*percent*	20.7		17.4	14.6	*2019*	10
2.08	Projected Child Food Insecurity Rate	*percent*	23.4		18.5		*2021*	10
1.94	Substantiated Child Abuse Rate	*cases/ 1,000 children*	10	8.7	6.8		*2020*	3
1.86	Blood Lead Levels in Children (>=10 micrograms per deciliter)	*percent*	1.7		0.5		*2020*	19
1.58	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	5.8		1.9		*2020*	19
1.50	Children with Low Access to a Grocery Store	*percent*	4.3				*2015*	23

1.33	Children with Health Insurance	*percent*	97.1		95.2	94.3	*2019*	1
1.33	Consumer Expenditures: Childcare	*average dollar amount per consumer unit*	272.1		301.6	368.2	*2021*	7

SCORE	EDUCATION	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
1.86	4th Grade Students Proficient in English/Language Arts	*percent*	46.6		63.3		*2018-2019*	15
1.86	4th Grade Students Proficient in Math	*percent*	52.5		74.3		*2018-2019*	15
1.86	8th Grade Students Proficient in English/Language Arts	*percent*	43.1		58.3		*2018-2019*	15
1.86	8th Grade Students Proficient in Math	*percent*	39.5		57.3		*2018-2019*	15
1.81	Student-to-Teacher Ratio	*students/ teacher*	16.5				*2019-2020*	13
1.67	Consumer Expenditures: Education	*average dollar amount per consumer unit*	1196.7		1200.4	1492.4	*2021*	7

1.44	High School Graduation	*percent*	89.5	90.7	92		*2019-2020*	15
1.33	Consumer Expenditures: Childcare	*average dollar amount per consumer unit*	272.1		301.6	368.2	*2021*	7
0.25	People 25+ with a Bachelor's Degree or Higher	*percent*	32.5		28.3	32.1	*2015-2019*	1

SCORE	MATERNAL, FETAL & INFANT HEALTH	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.11	Babies with Low Birth Weight	*percent*	10.8		8.5	8.2	*2020*	17
2.11	Babies with Very Low Birth Weight	*percent*	1.7		1.4	1.3	*2020*	17
1.78	Infant Mortality Rate	*deaths/ 1,000 live births*	8.6	5	6.9		*2019*	17
1.67	Preterm Births	*percent*	11.4	9.4	10.3		*2020*	17
1.58	Teen Pregnancy Rate	*pregnancies/ 1,000 females aged 15-17*	23.9		19.5		*2016*	17
1.53	Teen Birth Rate: 15-17	*live births/ 1,000 females aged 15-17*	7.2		6.8		*2020*	17
1.33	Consumer Expenditures: Childcare	*average dollar amount per consumer unit*	272.1		301.6	368.2	*2021*	7

1.00	Mothers who Received Early Prenatal Care	*percent*	72.4		68.9	76.1	*2020*	17
0.92	Mothers who Smoked During Pregnancy	*percent*	6.1	4.3	11.5	5.5	*2020*	17

Cuyahoga Data Sources

Key	Source Name
1	American Community Survey
2	American Lung Association
3	Annie E. Casey Foundation
4	CDC - PLACES
5	Centers for Disease Control and Prevention
6	Centers for Medicare & Medicaid Services
7	Claritas Consumer Buying Power
8	Claritas Consumer Profiles
9	County Health Rankings
10	Feeding America
11	Healthy Communities Institute
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	U.S. Bureau of Labor Statistics
22	U.S. Census - County Business Patterns
23	U.S. Department of Agriculture - Food Environment Atlas
24	U.S. Environmental Protection Agency
25	United For ALICE

SCORE	CHILDREN'S HEALTH	UNITS	LAKE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.00	Children with Low Access to a Grocery Store	*percent*	8				*2015*	23
1.83	Consumer Expenditures: Childcare	*average dollar amount per consumer unit*	315		301.6	368.2	*2021*	7
1.33	Children with Health Insurance	*percent*	95.7		95.2	94.3	*2019*	1
1.14	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	0.8		1.9		*2020*	19
1.03	Blood Lead Levels in Children (>=10 micrograms per deciliter)	*percent*	0.2		0.5		*2020*	19
0.92	Substantiated Child Abuse Rate	*cases/ 1,000 children*	3.9	8.7	6.8		*2020*	3
0.75	Projected Child Food Insecurity Rate	*percent*	14.8		18.5		*2021*	10
0.67	Child Food Insecurity Rate	*percent*	13.4		17.4	14.6	*2019*	10

SCORE	EDUCATION	UNITS	LAKE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.14	8th Grade Students Proficient in Math	*percent*	26.8		57.3		*2018-2019*	15
2.00	8th Grade Students Proficient in English/Language Arts	*percent*	21.7		58.3		*2018-2019*	15
1.86	Student-to-Teacher Ratio	*students/ teacher*	18.5				*2019-2020*	13

1.83	Consumer Expenditures: Childcare	*average dollar amount per consumer unit*	315		301.6	368.2	*2021*	7
1.83	Consumer Expenditures: Education	*average dollar amount per consumer unit*	1212.2		1200.4	1492.4	*2021*	7
1.36	4th Grade Students Proficient in Math	*percent*	75		74.3		*2018-2019*	15
1.19	People 25+ with a Bachelor's Degree or Higher	*percent*	27.4		28.3	32.1	*2015-2019*	1
1.17	High School Graduation	*percent*	93.7	90.7	92		*2019-2020*	15
0.58	4th Grade Students Proficient in English/Language Arts	*percent*	81.3		63.3		*2018-2019*	15

SCORE	MATERNAL, FETAL & INFANT HEALTH	UNITS	LAKE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
1.83	Consumer Expenditures: Childcare	*average dollar amount per consumer unit*	315		301.6	368.2	*2021*	7
1.28	Mothers who Received Early Prenatal Care	*percent*	70.3		68.9	76.1	*2020*	17
1.19	Mothers who Smoked During Pregnancy	*percent*	9.6	4.3	11.5	5.5	*2020*	17
1.03	Teen Pregnancy Rate	*pregnancies/ 1,000 females aged 15-17*	16.9		19.5		*2016*	17
0.97	Preterm Births	*percent*	8.5	9.4	10.3		*2020*	17
0.86	Teen Birth Rate: 15-17	*live births/ 1,000 females aged 15-17*	1.4		6.8		*2020*	17
0.78	Babies with Low Birth Weight	*percent*	6.8		8.5	8.2	*2020*	17
0.78	Babies with Very Low Birth Weight	*percent*	1.1		1.4	1.3	*2020*	17
0.78	Infant Mortality Rate	*deaths/ 1,000 live births*	1.8	5	6.9		*2019*	17

Lake Data Sources

Key	Source Name
1	American Community Survey
2	American Lung Association
3	Annie E. Casey Foundation
4	CDC - PLACES
5	Centers for Disease Control and Prevention
6	Centers for Medicare & Medicaid Services
7	Claritas Consumer Buying Power
8	Claritas Consumer Profiles
9	County Health Rankings
10	Feeding America
11	Healthy Communities Institute
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	U.S. Bureau of Labor Statistics
22	U.S. Census - County Business Patterns
23	U.S. Department of Agriculture - Food Environment Atlas
24	U.S. Environmental Protection Agency
25	United For ALICE

Lorain County

SCORE	CHILDREN'S HEALTH	UNITS	LORAIN COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.17	Consumer Expenditures: Childcare	*average dollar amount per consumer unit*	336.9		301.6	368.2	*2021*	7
1.83	Children with Low Access to a Grocery Store	*percent*	6.7				*2015*	23
1.56	Substantiated Child Abuse Rate	*cases/ 1,000 children*	7.1	8.7	6.8		*2020*	3
1.50	Child Food Insecurity Rate	*percent*	17.1		17.4	14.6	*2019*	10
1.42	Projected Child Food Insecurity Rate	*percent*	18.7		18.5		*2021*	10
1.33	Children with Health Insurance	*percent*	96.1		95.2	94.3	*2019*	1
1.03	Blood Lead Levels in Children (>=10 micrograms per deciliter)	*percent*	0.3		0.5		*2020*	19
1.03	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	1.4		1.9		*2020*	19

SCORE	EDUCATION	UNITS	LORAIN COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.17	Consumer Expenditures: Childcare	*average dollar amount per consumer unit*	336.9		301.6	368.2	*2021*	7
1.97	4th Grade Students Proficient in Math	*percent*	55.6		59.4		*2020-2021*	15
1.83	Consumer Expenditures: Education	*average dollar amount per consumer unit*	1217.2		1200.4	1492.4	*2021*	7
1.81	4th Grade Students Proficient in English/Language Arts	*percent*	55.3		56		*2020-2021*	15
1.69	Student-to-Teacher Ratio	*students/ teacher*	17.1				*2019-2020*	13
1.67	8th Grade Students Proficient in Math	*percent*	39.8		42.6		*2020-2021*	15
1.50	8th Grade Students Proficient in English/Language Arts	*percent*	53.5		52.7		*2020-2021*	15
1.50	High School Graduation	*percent*	91.5	90.7	92		*2019-2020*	15

1.25	People 25+ with a Bachelor's Degree or Higher	*percent*	24.9		28.3	32.1	*2015-2019*	1

SCORE	MATERNAL, FETAL & INFANT HEALTH	UNITS	LORAIN COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.17	Consumer Expenditures: Childcare	*average dollar amount per consumer unit*	336.9		301.6	368.2	*2021*	7
2.06	Babies with Very Low Birth Weight	*percent*	1.5		1.4	1.3	*2020*	17
2.06	Mothers who Received Early Prenatal Care	*percent*	67		68.9	76.1	*2020*	17
1.89	Preterm Births	*percent*	10.5	9.4	10.3		*2020*	17
1.75	Babies with Low Birth Weight	*percent*	9		8.5	8.2	*2020*	17
1.53	Teen Birth Rate: 15-17	*live births/ 1,000 females aged 15-17*	6.9		6.8		*2020*	17
1.42	Mothers who Smoked During Pregnancy	*percent*	12.6	4.3	11.5	5.5	*2020*	17
1.25	Teen Pregnancy Rate	*pregnancies/ 1,000 females aged 15-17*	19.9		19.5		*2016*	17
1.08	Infant Mortality Rate	*deaths/ 1,000 live births*	4.3	5	6.9		*2019*	17

Lorain Data Sources

Key	Source Name
1	American Community Survey
2	American Lung Association
3	Annie E. Casey Foundation
4	CDC - PLACES
5	Centers for Disease Control and Prevention
6	Centers for Medicare & Medicaid Services
7	Claritas Consumer Buying Power
8	Claritas Consumer Profiles
9	County Health Rankings
10	Feeding America
11	Healthy Communities Institute
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	U.S. Bureau of Labor Statistics
22	U.S. Census - County Business Patterns
23	U.S. Department of Agriculture - Food Environment Atlas
24	U.S. Environmental Protection Agency
25	United For ALICE

SCORE	CHILDREN'S HEALTH	UNITS	MEDINA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD
2.33	Consumer Expenditures: Childcare	*average dollar amount per consumer unit*	403.8		301.6	368.2	*2021*
1.83	Children with Low Access to a Grocery Store	*percent*	6.8				*2015*
1.72	Substantiated Child Abuse Rate	*cases/ 1,000 children*	7.4	8.7	6.8		*2020*
1.33	Children with Health Insurance	*percent*	95.4		95.2	94.3	*2019*
1.14	Blood Lead Levels in Children (>=10 micrograms per deciliter)	*percent*	0.2		0.5		*2020*
1.14	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	0.6		1.9		*2020*
0.75	Projected Child Food Insecurity Rate	*percent*	11.7		18.5		*2021*
0.50	Child Food Insecurity Rate	*percent*	10.6		17.4	14.6	*2019*

SCORE	EDUCATION	UNITS	MEDINA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD
2.33	Consumer Expenditures: Childcare	*average dollar amount per consumer unit*	403.8		301.6	368.2	*2021*
2.17	Consumer Expenditures: Education	*average dollar amount per consumer unit*	1490.7		1200.4	1492.4	*2021*
1.58	Student-to-Teacher Ratio	*students/ teacher*	18.3				*2019-2020*

1.50	8th Grade Students Proficient in Math	*percent*	62.1		57.3		*2018-2019*
1.00	4th Grade Students Proficient in Math	*percent*	86.3		74.3		*2018-2019*
0.86	4th Grade Students Proficient in English/Language Arts	*percent*	79		63.3		*2018-2019*
0.72	High School Graduation	*percent*	96.3	90.7	92		*2019-2020*
0.58	8th Grade Students Proficient in English/Language Arts	*percent*	74		58.3		*2018-2019*
0.25	People 25+ with a Bachelor's Degree or Higher	*percent*	33.9		28.3	32.1	*2015-2019*

SCORE	MATERNAL, FETAL & INFANT HEALTH	UNITS	MEDINA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD
2.33	Consumer Expenditures: Childcare	*average dollar amount per consumer unit*	403.8		301.6	368.2	*2021*
1.19	Mothers who Smoked During Pregnancy	*percent*	6.9	4.3	11.5	5.5	*2020*
1.11	Mothers who Received Early Prenatal Care	*percent*	74.7		68.9	76.1	*2020*
0.86	Teen Birth Rate: 15-17	*live births/ 1,000 females aged 15-17*	1.6		6.8		*2020*
0.86	Teen Pregnancy Rate	*pregnancies/ 1,000 females aged 15-17*	13.4		19.5		*2016*
0.78	Infant Mortality Rate	*deaths/ 1,000 live births*	1.8	5	6.9		*2019*
0.78	Preterm Births	*percent*	7.6	9.4	10.3		*2020*
0.75	Babies with Low Birth Weight	*percent*	5.7		8.5	8.2	*2020*

0.61	Babies with Very Low Birth Weight	*percent*	0.6		1.4	1.3	*2020*

Medina Data Sources

Key	Source Name
1	American Community Survey
2	American Lung Association
3	Annie E. Casey Foundation
4	CDC - PLACES
5	Centers for Disease Control and Prevention
6	Centers for Medicare & Medicaid Services
7	Claritas Consumer Buying Power
8	Claritas Consumer Profiles
9	County Health Rankings
10	Feeding America
11	Healthy Communities Institute
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	U.S. Bureau of Labor Statistics
22	U.S. Census - County Business Patterns
23	U.S. Department of Agriculture - Food Environment Atlas
24	U.S. Environmental Protection Agency
25	United For ALICE

Summit County

SCORE	CHILDREN'S HEALTH	UNITS	SUMMIT COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.00	Children with Low Access to a Grocery Store	*percent*	7.2				*2015*	23
1.83	Consumer Expenditures: Childcare	*average dollar amount per consumer unit*	307		301.6	368.2	*2021*	7
1.75	Projected Child Food Insecurity Rate	*percent*	19.1		18.5		*2021*	10
1.50	Child Food Insecurity Rate	*percent*	17.4		17.4	14.6	*2019*	10
1.33	Children with Health Insurance	*percent*	98		95.2	94.3	*2019*	1
1.03	Blood Lead Levels in Children (>=10 micrograms per deciliter)	*percent*	0.3		0.5		*2020*	19
1.03	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	1.2		1.9		*2020*	19
0.78	Substantiated Child Abuse Rate	*cases/ 1,000 children*	4.1	8.7	6.8		*2020*	3

SCORE	EDUCATION	UNITS	SUMMIT COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
1.86	4th Grade Students Proficient in English/Language Arts	*percent*	56.5		63.3		*2018-2019*	15
1.83	Consumer Expenditures: Childcare	*average dollar amount per consumer unit*	307		301.6	368.2	*2021*	7
1.83	Consumer Expenditures: Education	*average dollar amount per consumer unit*	1208.5		1200.4	1492.4	*2021*	7
1.81	Student-to-Teacher Ratio	*students/ teacher*	16.8				*2019-2020*	13

1.69	4th Grade Students Proficient in Math	*percent*	67.4		74.3		*2018-2019*	15
1.58	8th Grade Students Proficient in English/Language Arts	*percent*	51.1		58.3		*2018-2019*	15
1.58	8th Grade Students Proficient in Math	*percent*	48.7		57.3		*2018-2019*	15
1.39	High School Graduation	*percent*	91.1	90.7	92		*2019-2020*	15
0.25	People 25+ with a Bachelor's Degree or Higher	*percent*	32.5		28.3	32.1	*2015-2019*	1

SCORE	MATERNAL, FETAL & INFANT HEALTH	UNITS	SUMMIT COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.67	Babies with Low Birth Weight	*percent*	9.4		8.5	8.2	*2020*	17
2.39	Babies with Very Low Birth Weight	*percent*	1.7		1.4	1.3	*2020*	17
1.97	Teen Birth Rate: 15-17	*live births/ 1,000 females aged 15-17*	8		6.8		*2020*	17
1.83	Consumer Expenditures: Childcare	*average dollar amount per consumer unit*	307		301.6	368.2	*2021*	7
1.50	Preterm Births	*percent*	9.9	9.4	10.3		*2020*	17
1.36	Mothers who Smoked During Pregnancy	*percent*	11.1	4.3	11.5	5.5	*2020*	17
1.08	Teen Pregnancy Rate	*pregnancies/ 1,000 females aged 15-17*	18.7		19.5		*2016*	17
1.00	Mothers who Received Early Prenatal Care	*percent*	71.7		68.9	76.1	*2020*	17
0.83	Infant Mortality Rate	*deaths/ 1,000 live births*	6	5	6.9		*2019*	17

Summit Data Sources

Key	Source Name
1	American Community Survey
2	American Lung Association
3	Annie E. Casey Foundation
4	CDC - PLACES
5	Centers for Disease Control and Prevention
6	Centers for Medicare & Medicaid Services
7	Claritas Consumer Buying Power
8	Claritas Consumer Profiles
9	County Health Rankings
10	Feeding America
11	Healthy Communities Institute
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	U.S. Bureau of Labor Statistics
22	U.S. Census - County Business Patterns
23	U.S. Department of Agriculture - Food Environment Atlas
24	U.S. Environmental Protection Agency
25	United For ALICE

SCORE	CHILDREN'S HEALTH	UNITS	WAYNE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.00	Children with Health Insurance	*percent*	75.8		95.2	94.3	*2019*	1
1.61	Substantiated Child Abuse Rate	*cases/ 1,000 children*	7.6	8.7	6.8		*2020*	2
1.33	Children with Low Access to a Grocery Store	*percent*	3.6				*2015*	22
1.17	Consumer Expenditures: Childcare	*average dollar amount per consumer unit*	234.9		301.6	368.2	*2021*	6
1.03	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	1.1		1.9		*2020*	18
1.00	Child Food Insecurity Rate	*percent*	14.7		17.4	14.6	*2019*	9
0.92	Projected Child Food Insecurity Rate	*percent*	15.5		18.5		*2021*	9
0.86	Blood Lead Levels in Children (>=10 micrograms per deciliter)	*percent*	0.2		0.5		*2020*	18

SCORE	EDUCATION	UNITS	WAYNE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
1.69	People 25+ with a Bachelor's Degree or Higher	*percent*	22.2		28.3	32.1	*2015-2019*	1
1.53	Student-to-Teacher Ratio	*students/ teacher*	16.2				*2019-2020*	12
1.42	8th Grade Students Proficient in Math	*percent*	60		42.6		*2020-2021*	14
1.17	4th Grade Students Proficient in Math	*percent*	74		59.4		*2020-2021*	14

1.17	Consumer Expenditures: Childcare	*average dollar amount per consumer unit*	234.9		301.6	368.2	*2021*	6
1.17	Consumer Expenditures: Education	*average dollar amount per consumer unit*	968.6		1200.4	1492.4	*2021*	6
1.00	4th Grade Students Proficient in English/Language Arts	*percent*	68.1		56		*2020-2021*	14
1.00	8th Grade Students Proficient in English/Language Arts	*percent*	65.6		52.7		*2020-2021*	14
1.00	High School Graduation	*percent*	95.8	90.7	92		*2019-2020*	14

SCORE	MATERNAL, FETAL & INFANT HEALTH	UNITS	WAYNE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.50	Infant Mortality Rate	*deaths/ 1,000 live births*	9	5	6.9		*2019*	16
2.39	Mothers who Received Early Prenatal Care	*percent*	57.2		68.9	76.1	*2020*	16
1.31	Teen Birth Rate: 15-17	*live births/ 1,000 females aged 15-17*	4.3		6.8		*2020*	16
1.19	Mothers who Smoked During Pregnancy	*percent*	10.3	4.3	11.5	5.5	*2020*	16
1.17	Consumer Expenditures: Childcare	*average dollar amount per consumer unit*	234.9		301.6	368.2	*2021*	6
1.06	Babies with Low Birth Weight	*percent*	7		8.5	8.2	*2020*	16
0.86	Teen Pregnancy Rate	*pregnancies/ 1,000 females aged 15-17*	12.2		19.5		*2016*	16
0.78	Preterm Births	*percent*	7.6	9.4	10.3		*2020*	16
0.61	Babies with Very Low Birth Weight	*percent*	0.7		1.4	1.3	*2020*	16

Wayne Data Sources

Key	Source Name
1	American Community Survey
2	American Lung Association
3	Annie E. Casey Foundation
4	CDC - PLACES
5	Centers for Disease Control and Prevention
6	Centers for Medicare & Medicaid Services
7	Claritas Consumer Buying Power
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Appendix D: Community Input Assessment Tools

CCF identified key community stakeholders to provide vital perspectives and context around important community health issues. CCF and HCI worked to develop a questionnaire to determine what a community needs to be healthy, what barriers to health exist in the community, how COVID-19 has impacted health in the community and how the challenges identified might be addressed in the future. Below is the complete Key Stakeholder Interview Guide:

WELCOME: Cleveland Clinic ***{hospital name}*** is in the process of conducting our 2022 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 ***{at organization}*** in the community. During this interview, we will ask a series of questions related to health issues in your community. Our ultimate goal is to gain various perspectives on the major issues affecting the population that your organizations serves and how to improve health in your community. We hope to get through as many questions as possible and hear your perspective as much as time allows.

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

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

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

Section #1: Introduction

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

Section #2: Community Health and Well-being

- From your perspective, what does a community need to be healthy?

- What do you believe are the 2-3 most important issues that must be addressed to improve health and quality of life in your community?

Section #3: Barriers to Health

- What health disparities appear most prevalent in your community?
- What are the barriers or challenges to improving health in the community?
    - What makes some people healthy in the community while others experience poor health?
    - What particular parts of the community or geographic areas that are underserved or under-resourced?
    - What services are most difficult to access?
- What could be done to promote health equity?

Section #4: COVID-19

- How has COVID-19 impacted health in your community?
    - What were the most significant health concerns prior to the pandemic vs now?
    - What populations have been most affected by COVID-19?
- How has COVID-19 impacted access to care in the community?
    - What about access to mental health or substance use treatment in the community?
    - What about emergency and preventative care services?

Section #5: Addressing the Challenges & Solutions

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

Section #6: Conclusion

- 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.

Appendix E: Community Partners and Resources

This section identifies other facilities and resources available in the community served by Cleveland Clinic Main Campus that are available to address community health needs.

Federally Qualified Health Centers

Ohio's Association of Community Health Centers (OACHC) is a not-for-profit membership association representing Federally Qualified Health Centers (FQHCs).[47] FQHCs are established to promote access to ambulatory care in areas designated as medically underserved. These clinics provide primary care, mental health, and dental services for lower-income members of the community. FQHCs receive enhanced reimbursement for Medicaid and Medicare services and most also receive federal grant funds under Section 330 of the Public Health Service Act. OACHC represents Ohio's 57 Community Health Centers at 400 locations, including multiple mobile units The following FQHC clinics and networks operate in the Cleveland Clinic Main Campus Community:

- Asian Services in Action, Inc.
- Care Alliance
- Health Source of Ohio
- MetroHealth Community Health Centers (MHCHC)
- Neighborhood Family Practice
- Northeast Ohio Neighborhood Health Services
- Signature Health, Inc.
- The Centers

Hospitals

In addition to several Cleveland Clinic hospitals in Northeast Ohio, the following is a list of other hospital facilities located in the Cleveland Clinic Main Campus Community:

- Grace Hospital
- MetroHealth Medical Centers (Multiple Locations)

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

- St. Vincent Charity Medical Center
- University Hospitals (Multiple Locations)

Other Community Resources

A wide range of agencies, coalitions, and organizations that provide health and social services is available in the region served by Cleveland Clinic Main Campus . United Way 2-1-1 Ohio maintains a large, online database to help refer individuals in need to health and human services in Ohio. This is a service of the Ohio Department of Social Services and is provided in partnership with the Council of Community Services, The Planning Council, and United Way chapters in Cleveland. United Way 2-1-1 Ohio 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
- Health Care
- 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: http://www.211oh.org/

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

Implementation Strategy Report

2022

CLEVELAND CLINIC MAIN CAMPUS
2022 IMPLEMENTATION STRATEGY REPORT
2022 Community Health Needs Assessment
Implementation Strategy Report for Years 2023 – 2025

TABLE OF CONTENTS

CLEVELAND CLINIC MAIN CAMPUS
2022 IMPLEMENTATION STRATEGY REPORT

I. INTRODUCTION AND PURPOSE

This written plan is intended to satisfy the requirements set forth in the Internal Revenue Code Section 501(r)(3) regarding community health needs assessments and implementation strategies. The overall purpose of the Implementation Strategy is to align the hospital's limited resources, program services, and activities with the Cleveland Clinic Main Campus (Main Campus) findings of the Community Health Needs Assessment ("CHNA"). The Implementation Strategy Report (ISR) includes the priority community health needs identified during the 2022 CHNA for Main Campus as well as the pediatric population of Cleveland Clinic Children's. This report includes strategies for the years 2023 through 2025.

A. Description of Hospital

The Main Campus is located in the City of Cleveland and is the tertiary care hospital that is the flagship of the Cleveland Clinic health system, which includes an academic medical center near downtown Cleveland, fourteen regional hospitals in Northeast Ohio, a children's hospital, a children's rehabilitation hospital, five southeast Florida hospitals, and a number of other facilities and services across Ohio; Florida; Nevada; Toronto, Canada; Abu Dhabi, UAE; and London, England. The Main Campus is the location of a medical school; a research institute; 262 outpatient clinics; 20 specialty institutes, including for heart care, digestive disease, cancer, and eye care; 1,298 staffed beds;[48] and supporting labs and facilities on a 173-acre campus. Additional information about Cleveland Clinic is available at: https://my.clevelandclinic.org/.

Cleveland Clinic Children's is located on Cleveland Clinic's Main Campus in Cleveland, Ohio, and has provided world-class, family-centered care to infants, children, adolescents, and families since 1921. Cleveland Clinic Children's also serves as a health resource for patients locally, regionally, nationally, and internationally. Additional information on Cleveland Clinic Children's and its services is available at: https://my.clevelandclinic.org/pediatrics.

Cleveland Clinic's mission is:

Caring for life, researching for health, and educating those who serve.

[48] For the purpose of this report and consistent methodology, the Cleveland Clinic MD&A (Q4-2022) 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.

II. COMMUNITY DEFINITION

For purposes of this report, the Main Campus Hospital community definition is an aggregate of 22 zip codes in Cuyahoga County comprising approximately 75% of emergency department visits in 2021 (Figure 1). Cleveland Clinic Children's community definition is an aggregate of 71 zip codes in Cuyahoga, Lake, Lorain, Medina, Summit, and Wayne Counties comprising approximately 75% of inpatient, outpatient, and emergency department visits in 2021 (Figure 2).

Figure 1: The Cleveland Clinic Main Campus Community Definition

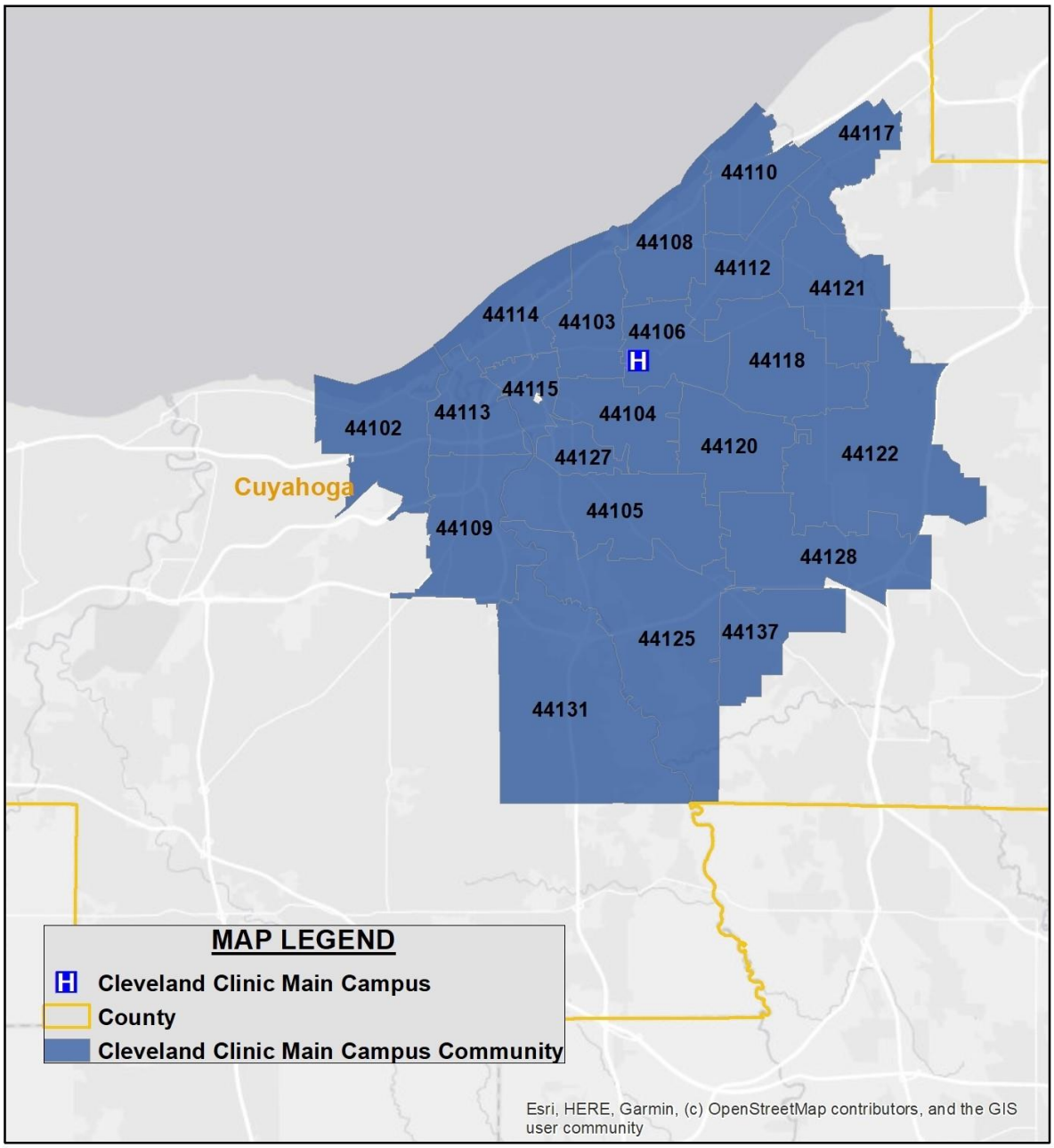
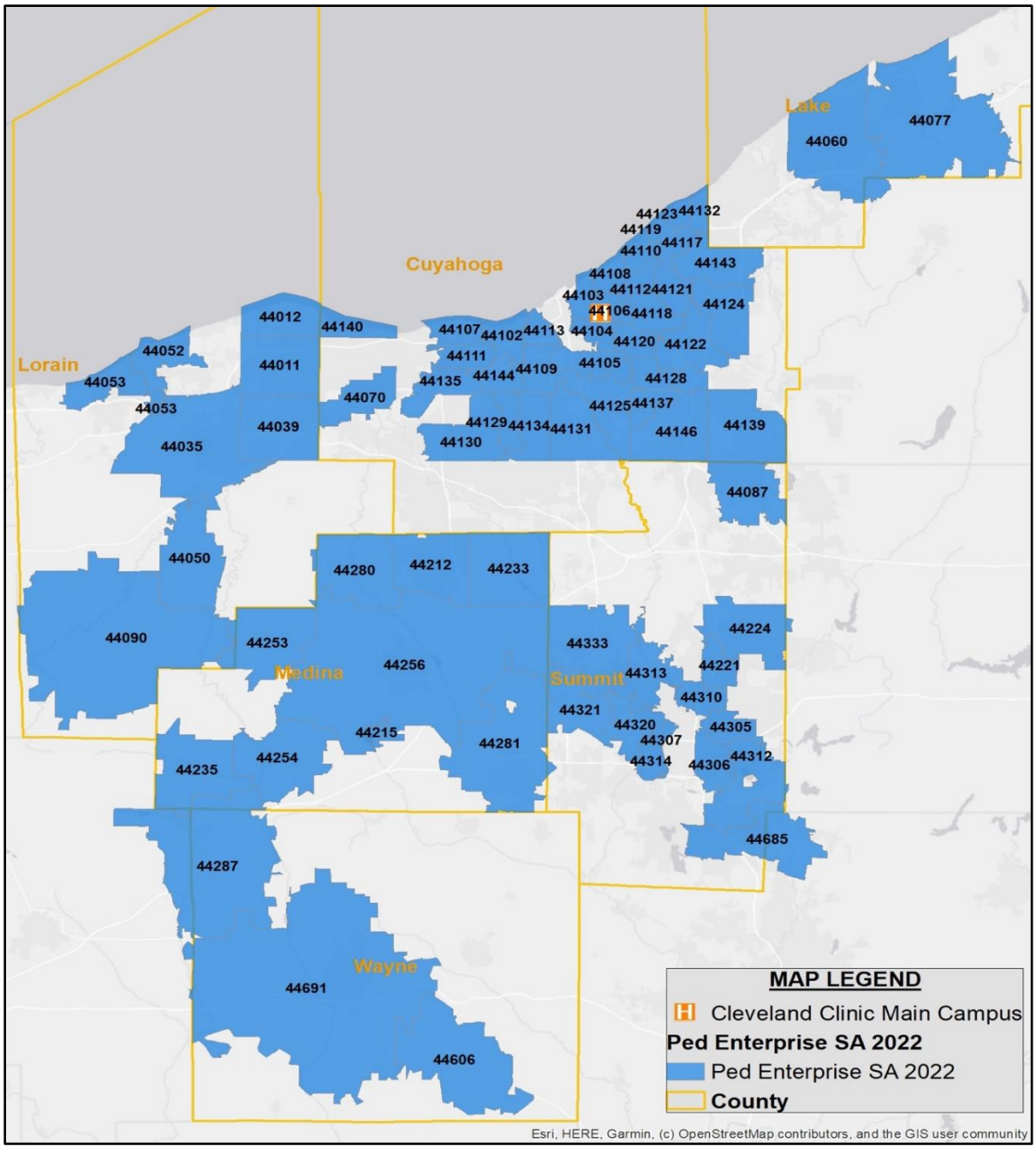


Figure 2: Cleveland Clinic Children's Community Definition



III. HOW IMPLEMENTATION STRATEGY WAS DEVELOPED

This Implementation Strategy was developed by members of leadership at Cleveland Clinic representing several departments of the organization, including clinical administration, medical operations, nursing, finance, population health, and community relations. This team incorporated input from the hospital's community and local non-profit organizations to prioritize selected strategies and determine possible collaborations. Alignment with county Community Health Assessments (CHA), as well as the State Health

Assessment (SHA), was also considered. Leadership at the Cleveland Clinic 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

Cleveland Clinic Main Campus's (including Cleveland Clinic Children's) prioritized community health needs as determined by analyses of quantitative and qualitative data include:

- Access to Healthcare
- Behavioral Health
- Chronic Disease Prevention and Management
- Maternal and Child Health
- Socioeconomic Issues

Additional Community Health Themes
In addition to the prioritized community health needs, themes of health equity, social determinants of health, and medical research and education are intertwined in all community health components and impact multiple areas of community health strategies and delivery.

Health Equity
Health Equity issues in our communities were illuminated by COVID-19. They focus on the fair distribution of health determinants, outcomes, and resources across communities.[49] Health Equity and the reduction of health disparities are indicated as overarching themes in all our prioritized needs from the 2022 CHNA. It is described in detail and specifically as it relates to Cleveland Clinic Main Campus and Cleveland Clinic Children's in both the Disparities and Health Equity section of the CHNA report as well as in the Synthesis and Prioritization section. Special consideration has been given to addressing prioritized health needs through a health equity lens in this Cleveland Clinic Main Campus Implementation Strategy report.

Social Determinants of Health
Social determinants of health (SDOH) are the conditions in the environment where people are born, live, learn, work, play, worship, and age that affects a wide range of health, functioning, and quality of life outcomes and risks. Social determinants of health (SDOH) are major drivers of behaviors that impact individual and community health outcomes. The 2022 CHNA identified food security, affordable housing, employment, transportation, health literacy, structural racism, poverty, and environmental risk factors as significant concerns. Further, the primary and secondary impacts of COVID-19 have exacerbated many health disparities and barriers that were present before the pandemic. Socioeconomic Issues for this report are defined as a subset of social determinants of health (SDOH). Prevention & Safety, Affordable Housing, Violence, Falls, and Environmental Issues were the prioritized health needs described by primary and secondary data.

[49] Klein R, Huang D. Defining and measuring disparities, inequities, and inequalities in the Healthy People initiative. National Center for Health Statistics. Center for Disease Control and Prevention. https://www.cdc.gov/nchs/ppt/nchs2010/41_klein.pdf

Medical Research and Health Professions Education

Cleveland Clinic has a tripartite mission to care for the sick and to improve patient care through research and education. Through research, we discover cures and treatment of diseases affecting our communities. This cross-cutting issue was evident in addressing the emergent pandemic of COVID-19. Our education programs train qualified healthcare providers to support the needs of our patients and communities, reducing healthcare access issues. This has been of historical importance to the work, care, and mission of Cleveland Clinic and will continue to be incorporated as Main Campus works to accomplish this implementation strategy.

Education has been a vital component of Cleveland Clinic since its founding in 1921. Today, our vision remains unchanged — teaching those who serve. Cleveland Clinic is dedicated to training the next generation of healthcare professionals through our worldwide training and education programs. We provide a wide range of high-quality medical education that includes accredited training programs for residents, physicians, nurses, and allied health professionals. By educating medical professionals, we ensure that our communities receive the highest level of medical care and will have access to highly trained health professionals in the future.

Research into diseases and their cures is an investment in long-term health. Since its founding, research has been an integral part of Cleveland Clinic's mission. The founders believed it was not only important to treat patients, but also to investigate the causes of disease. A century later, Cleveland Clinic is at the forefront of scientific discovery. Our researchers are leaders in growing fields transforming the way medicine is delivered, including precision medicine, genomics, population health, and immuno-oncology. Lab-based and translational researchers work to uncover novel biological pathways that contribute to a host of diseases, including cancer, cardiovascular and metabolic diseases, brain and eye diseases, and diseases of the inflammation and immune systems. They work closely with clinical researchers from all areas of Cleveland Clinic to translate basic biological research discoveries into new diagnostic tests and treatments—including medical devices and therapeutics—that will benefit patients worldwide. Through research, we are committed to improving care and finding tomorrow's cures.

In his State of the Clinic address on January 18, 2023, Tom Mihaljevic, MD, CEO, reported goals for caring for our community:

> **"The conditions in which we work and live are powerful determinants of health.**
>
> **When caring for the health of a community, medical care only contributes to a small portion. More influential factors are employment, environment, education, and behaviors.**
>
> **We are coming closer to addressing the root causes of unequal health.**
>
> **Cleveland Clinic heals, hires, and invests.**
>
> **As the largest employer in Ohio and many communities we serve, we are committed to providing good jobs and career paths, livable wages, and affordable healthcare benefits.**
>
> **Yet, our community is challenged in many ways. Environmentally, we continue to face three serious threats to the lives of children: lead, infant mortality, and hunger.**
>
> **Cleveland Clinic brings our collective voice to those who have not developed a voice of their own, children."**

COVID-19 Considerations

The COVID-19 global pandemic declared in early 2020 has caused extraordinary challenges for healthcare systems across the world including Cleveland Clinic. Keeping front line workers and patients safe, securing protective equipment, developing testing protocols, and helping patients and families deal with the isolation needed to stop the spread of the virus all took priority as the pandemic took hold.

Many of the community benefit strategies noted in the previous 2019 implementation strategy were temporarily paused or adjusted to comply with current public health guidelines to ensure the health and safety of patients, staff, and other participants. Many of the strategies included in the 2023-2025 implementation strategy are a continuation or renewal of those that were paused during the pandemic as the community needs identified in the 2022 CHNA did not change greatly from those identified in the 2019 CHNA.

See the 2022 Cleveland Clinic Main Campus and other Cleveland Clinic CHNAs for more information: www.clevelandclinic.org/CHNAReports

V. NEEDS HOSPITAL WILL ADDRESS

Each Cleveland Clinic hospital provides numerous services and programs in effort to address the health needs of the community. Implementation of our services focuses on addressing structural factors important for community health, strengthening trust with residents and stakeholders, ensuring community voice in developing strategies, and evaluating our strategies and programs.

Strategies within the ISRs are included according to the prioritized list of needs developed during the 2022 CHNA. These hospitals' community health initiatives combine Cleveland Clinic and local non-profit organizations' resources in unified efforts to improve health and health equity for our community members, especially low-income, underserved, and vulnerable populations.

A. Access to Healthcare

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

Cleveland Clinic continues to evaluate methods to improve patient access to care. All Cleveland Clinic hospitals will continue to provide medically necessary services to all patients regardless of race, color, creed, gender, country of national origin, or ability to pay. The financial assistance policy can be accessed here: Cleveland Clinic Financial Assistance.

Access to Healthcare Initiatives for 2023-2025 include:

Initiatives Including Collaborations and Resources Allocated	Anticipated Impacts
A Patient Financial Advocates assist patients in evaluating eligibility for financial assistance or public health insurance programs	Increase the proportion of eligible individuals who are enrolled in various assistance programs
B Address digital equity, utilize medically secure online, and mobile platforms, connect patients with Cleveland Clinic providers for telehealth and virtual visits	Overcome geographical and transportation barriers, improve access to specialized care
C Continue to embed community and clinical services at the Cleveland Clinic Langston Hughes Community Health and Education Center	Promote neighborhood healthcare access and model of clinical-community partnership

Behavioral Health

Main Campus's 2022 CHNA also identified Behavioral Health as a prioritized need area. Behavioral Health encompasses Mental Health and Substance Use Disorders. Mental Health includes suicide, depression, and self-reported poor mental health rates. Substance Use Disorder relates to alcohol and drug use including drug overdoses. Community members described mental health challenges in the community, exacerbated by COVID-19 related stressors, resulting in increased alcohol and drug use starting in adolescence as a means of coping.

Behavioral Health Initiatives for 2023-2025 include:

Initiatives Including Collaborations and Resources Allocated	Anticipated Impacts
A Continued collaboration in Northeast Ohio Hospital Opioid Consortium and Cuyahoga County Opioid Task Force in coordinated efforts to reduce the widespread effect of the heroin and opioid crisis in Northeast Ohio	Reduce the number of individuals with heroin or opioid addiction and dependence
B Provide substance abuse education classes/presentations to local residents and schools, including Be the Boss curriculum with Bolton Elementary school and Ghetto Therapy in hospital facilities	Increase awareness of treatment, reduce stigma, and improve early identification of behavioral health conditions

C. Chronic Disease Prevention & Management

Main Campus's CHNA identified chronic disease and other health conditions as prevalent in the community (ex. heart disease, stroke, diabetes, respiratory diseases, hypertension, obesity, cancer, COVID-19). Prevention and management of chronic disease initiatives seek to increase healthy behaviors in nutrition, physical activity, and tobacco cessation.

Chronic Disease Prevention & Management Initiatives for 2023-2025 include:

Initiatives Including Collaborations and Resources Allocated	Anticipated Impacts
A Implement health promotion, health education, support groups, and outreach events related to heart disease and stroke, cancer, respiratory disease, women's health, and obesity, therefore reducing behavioral risk factors Main Campus initiatives include Fairfax Community Health Day, partnership with Bolton School 100th St project, YMCA Diabetes Prevention Program	Decrease smoking, improve physical activity, improve nutrition, increase the number of individuals with a regular source of care, increase cancer screening rates, improve screening follow-up rates
B Provide free physical exams, flu shots, exercise courses, health education, cooking classes, and tobacco cessation programs for the surrounding communities at the Cleveland Clinic Langston Hughes Community Health and Education Center in Fairfax	Decrease smoking, improve physical activity, improve nutrition, improve self-efficacy associated with healthy eating, increase the number of individuals who receive a regular well-check, improve vaccination rates
C Promote early cancer detection through community outreach and education, screening promotion, and patient navigation. Relevant programs include *Pink and Beyond,* a collaboration between THE WORD Church and Cleveland Clinic; a partnership between the National Breast Cancer Foundation and Taussig Cancer Institute; and *Stopping Cancer in its Tracks*, a Cuyahoga County collaborative of 25 churches	Increase cancer screening rates, improve screening follow-up rates, and reduce the number of patients who present with late-stage cancers
D In partnership with the YWCA, provide *The Wellness Avengers* healthy lifestyle classes for children In partnership with local schools, offer the *Healthy Strides for Kids* running program to elementary students	Improve physical activity, improve nutrition
E Staff the mobile *School-Based Health Center* that provides care to K-12 students at local schools	Improve access to primary care, reduce the number of missed school days

D. Maternal & Child Health

Main Campus's 2022 CHNA continued to identify Maternal and Child Health as a prioritized health need in the community. Secondary data indicators include a range of children's health needs from babies with low birth weight to consumer expenditures on childcare. Primary data describes disparities among low-income and ethnic minority populations and link access to healthcare with prenatal care. Infant mortality rates at the local, state, and national levels have been particularly high for Black infants.

Maternal & Child Health Initiatives for 2023-2025 include:

Initiatives Including Collaborations and Resources Allocated	Anticipated Impacts
A Through the Cleveland Clinic enterprise, continue participation with First Year Cleveland, Birthing Beautiful Communities to pilot a perinatal support specialist program	Gather data, align programs, and coordinate a systemic approach to improving infant mortality in communities
B Introduce CCF's Center for Infant and Maternal Health initiative in Cuyahoga, Lorain, and Summit counties. Provide OB navigators to help connect patients to community resources and a midwife provider at Main Campus to expand patient access in vulnerable Cleveland neighborhoods	Improve the preterm birth rate, increase pregnancy spacing, reduce preterm birth inequity
C Expand capacity to offer the Centering Pregnancy and Centering Parent groups' prenatal care model to expecting mothers and community members	Improve the preterm birth rate, increase pregnancy spacing, reduce preterm birth inequity
D Continue Cleveland Clinic OB patient navigation programming using Community Health Workers and/or the co-location of community organizations with hospital facilities	Ensure connection to OB medical services, improve health equity for pregnant persons

E. Socioeconomic Issues

Main Campus's 2022 CHNA demonstrated that health needs are multifaceted, involving medical as well as socioeconomic concerns. The assessment identified food security, affordable housing, employment, transportation, health literacy, structural racism, poverty, and environmental risk factors as significant concerns. Further, the primary and secondary impacts of COVID-19 have exacerbated many health disparities and barriers that were present before the pandemic. Socioeconomic Issues for this report are defined as a subset of social determinants of health (SDOH). Prevention & Safety, Affordable Housing, Violence, Falls, and Environmental Issues were prioritized socioeconomic issues described by primary and secondary data.

Socioeconomic Issues Initiatives for 2023-2025 include:

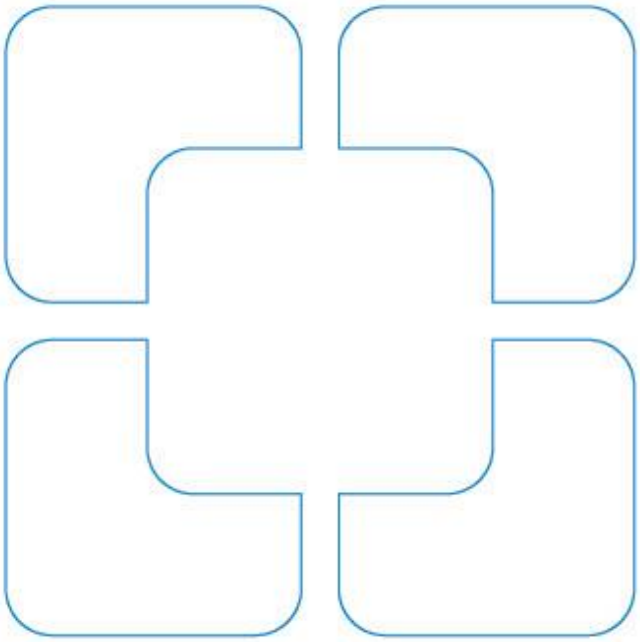
Initiatives Including Collaborations and Resources Allocated	Anticipated Impacts
A Continue a Cleveland Clinic common community referral data platform to coordinate services and ensure optimal communication	Improve active referrals to community-based organizations, non-profits, and other healthcare facilities; track referral outcomes
B Continue Cleveland Clinic patient navigation programming using Community Health Workers and/or the co-location of community organizations with hospital facilities	Ensure connection to medical, social, and behavioral services; improve health equity
C Partner with community-based organizations to improve equitable access to healthy foods	Improve self-efficacy associated with healthy eating, improve nutrition
D Partner with organizations to open a Fairfax site grocery store and mixed-income apartment complex	Improve healthy food access and availability of affordable housing
E In partnership with the *Governor's Lead Safe Coalition* and the Ohio Department of Health, identify and treat children impacted by lead poisoning and identify risk factors and risk areas	Reduce lead poisoning, improve health outcomes for children disproportionality exposed to lead within City of Cleveland

Socioeconomic Issues (continued)

	Initiatives Including Collaborations and Resources Allocated	Anticipated Impacts
F	Provide workforce development and training opportunities for youth K-12 in clinical and non-clinical areas, empowering Northeast Ohio's next generation of leaders	Improve health equity, improve trust in providers
G	Sponsor the Canopy Child Advocacy Center to coordinate sexual abuse investigations and support children throughout Cuyahoga County	Minimize the impact of trauma and violence on overall health and wellbeing
H	Partner with Metro Health Medical Center and Rainbow Babies and Children's Hospital to support the *Reach Out and Read* program	Promote literacy, increase access to age-appropriate books

While this ISR outlines specific strategies and programs identified to address the 2022 CHNA prioritized areas of Access to Healthcare, Behavioral Health, Chronic Disease Prevention and Management, Maternal and Child Health, and Socioeconomic Issues, it does not reflect all the work being done by Cleveland Clinic Main Campus (including Cleveland Clinic Children's) 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 Cleveland Clinic Main Campus 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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