Cleveland Clinic
Euclid Hospital

Community Health Needs Assessment

2022

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Executive Summary

This Community Health Needs Assessment (CHNA) was conducted by Cleveland Clinic Euclid Hospital (the Euclid Hospital 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]

Located on 17 acres along the Lake Erie shoreline, Euclid Hospital is home to one of the region's leading rehabilitation and orthopedic centers. The 166 staffed bed[2] hospital offers a complete continuum of care: emergency services, sub-acute care, rehabilitation and outpatient care. Founded in 1907 as Glenville Hospital, Euclid Hospital was constructed at its existing location in 1952.

The hospital has a strong history of caring for the community, which is a tradition that continues today. Euclid Hospital has teamed up with The Cleveland Clinic Foundation and other area hospitals to form the Cleveland Clinic Health System for improved quality and lower cost of care to Northeast Ohio residents. Additional information on the hospital and its services is available at: https://my.clevelandclinic.org/locations/euclid-hospital.

The hospital is part 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.

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. We treat patients and fellow caregivers as family and Cleveland Clinic as our home. Our vision is to become the best place to receive healthcare anywhere, and the best place to work in healthcare. Our goals for achieving that are bold, but reachable: To serve more patients, create more value and improve the well-being of all caregivers. As we grow and double the number of patients served by 2024, everything we do and every place we are located will bear the unmistakable stamp of One Cleveland Clinic –with the same quality, experience and Care Priorities at every location.

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

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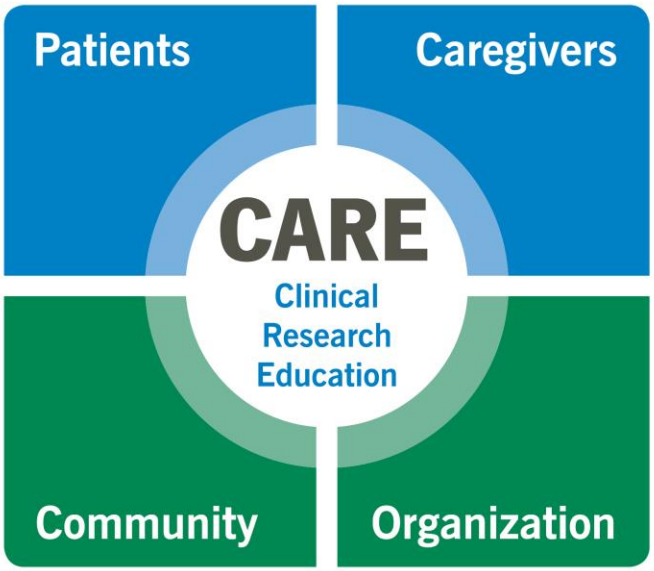
[1] Internal Revenue Service, Community Health Needs Assessment for Charitable Hospital Organizations – Section 501 (c) (3), https://www.irs.gov/charities-non-profits/charitable-organizations/requirements-for-501c3-hospitals-under-the-affordable-care-act-section-501r

[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.

[3] The Cleveland Clinic Mission, Vision and Values https://my.clevelandclinic.org/about/overview/who-we-are/mission-vision-values

- 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 part of the social fabric of the community, creating opportunities for those around us and making the communities we serve healthier. 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

[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]

Additional information about Cleveland Clinic is available at: https://my.clevelandclinic.org/.

Each Cleveland Clinic hospital is also 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.

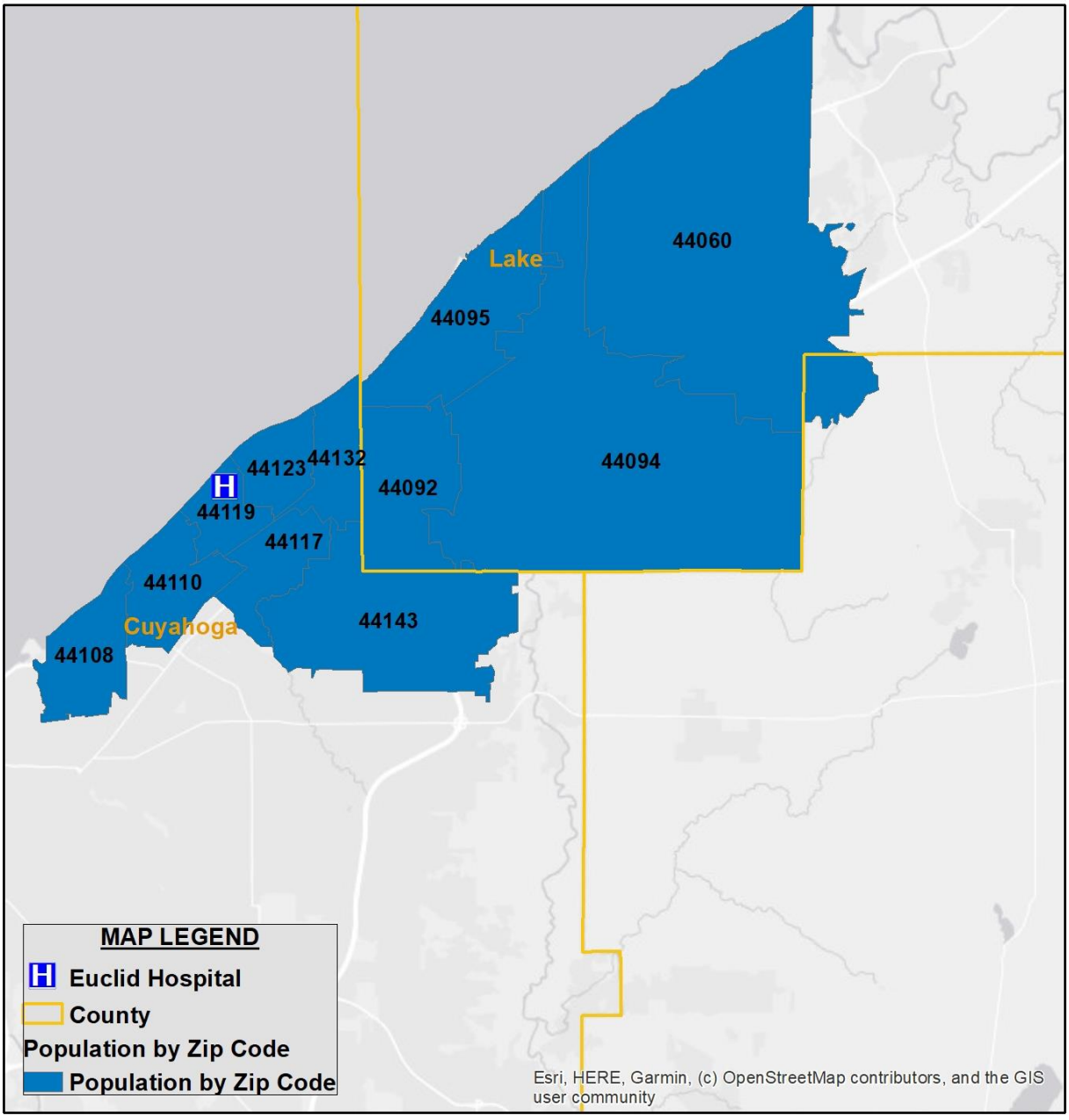
These assessments are conducted using widely accepted methodologies to identify the significant health needs of a specific community. The assessments also are conducted to comply with federal and state laws and regulations including IRS requirements for 501(c)(3) Hospitals under the Affordable Care Act.[7]

Community Definition

The community definition describes the zip codes where approximately 75% of Euclid Hospital patients reside. Figure 2 shows the service area for the Euclid Hospital 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: Euclid Hospital 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 Euclid Hospital Community Definition—an aggregate of the 11 zip codes described above in the Community Definition section.
- Cuyahoga and Lake Counties—the two counties comprising the Euclid Hospital Community Definition

Primary Data Summary

Qualitative data collected from community members through key stakeholder interviews and a community engagement session comprised the primary data component of the CHNA and helped to inform 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 Euclid Hospital 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 prioritized health topic. Mental health secondary data indicators included suicide, Alzheimer's disease, depression and self-reported poor mental health rates. Similarly, Substance Use Disorder data included 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 33).

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 ethnic minority and refugee populations and populations with low income, and link access to healthcare with prenatal care.

Socioeconomic Issues

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.

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 the Euclid Hospital Community in both the Disparities and Health Equity section (page 25) of the report as well as in the Synthesis and Prioritization section (page 33). Special consideration will be given to addressing prioritized health needs through a health equity lens in the Euclid Hospital 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.

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 Euclid Hospital moves toward development of their implementation strategy report.

[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

COMMUNITY HEALTH NEEDS ASSESSMENT
Euclid Hospital

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 Promotion

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 Euclid Hospital 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 Euclid Hospital Community Definition.

Geography and Data Sources

Data are presented in this section at the geographic level of the Euclid 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[10] one-year (2019) or five-year (2015-2019) estimates unless otherwise indicated.

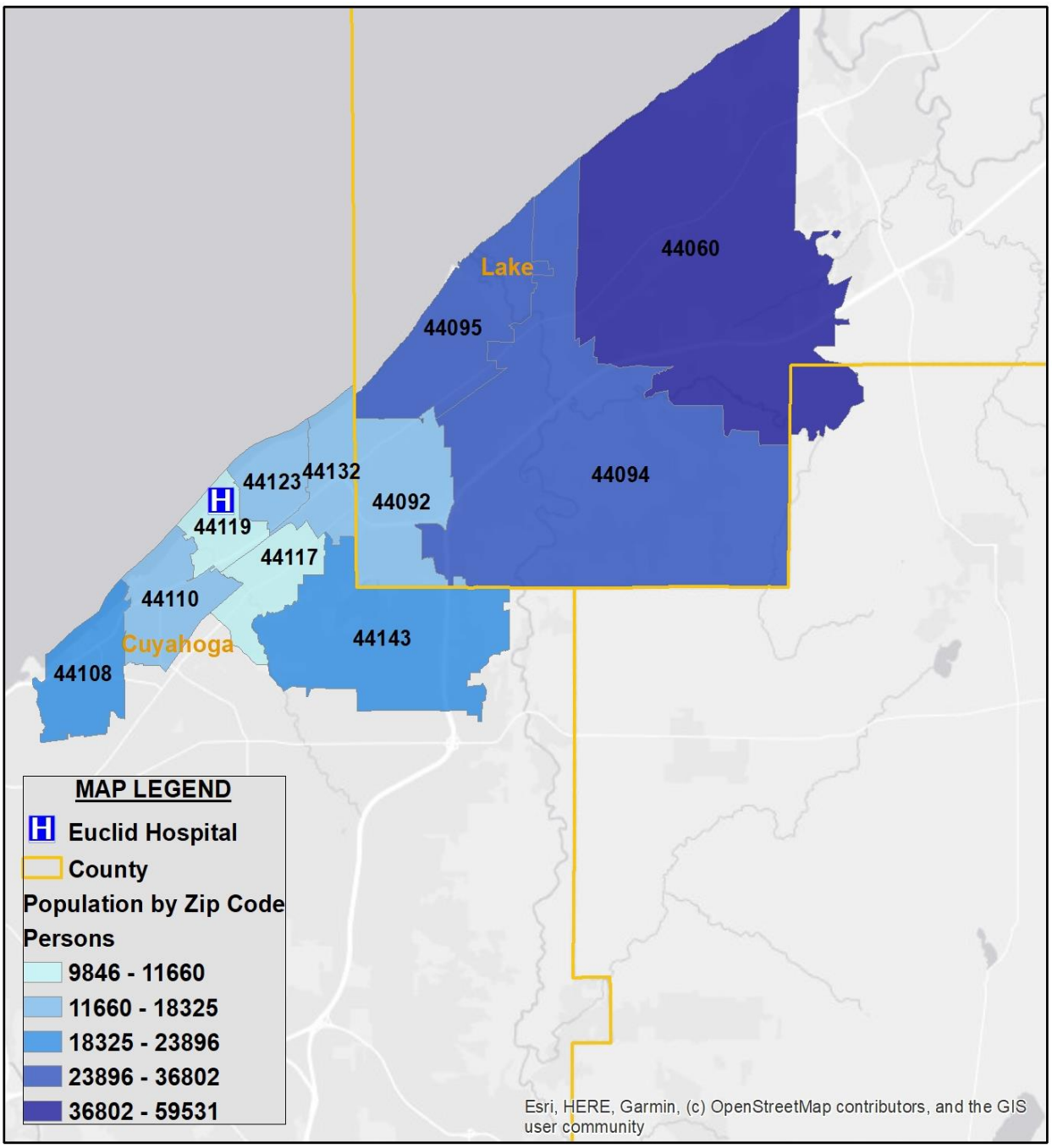
Population

According to the 2022 Claritas Pop-Facts® population estimates, the Euclid Hospital Community has an estimated population of 261,714 persons. Figure 3 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 Euclid Hospital Community is zip code 44060 (Lake) with a population of 59,531.

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

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

Figure 3: Population by Zip Code

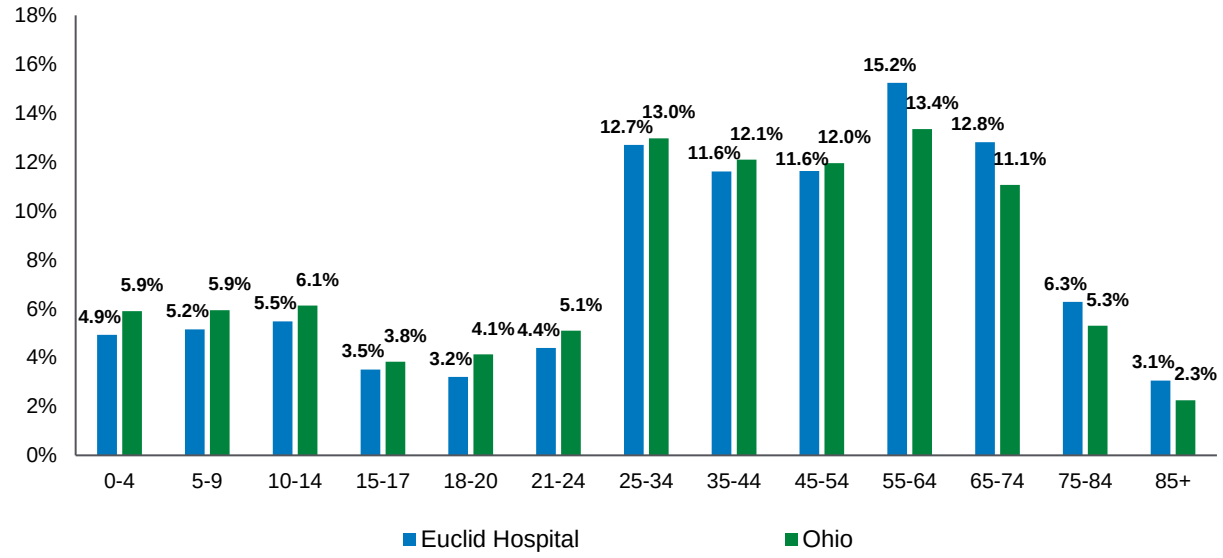


County values- Claritas Pop-Facts® (2022 population estimates)

Age

Children (Ages 0-17) comprised 19.1% of the population in the Euclid Hospital Community, which is less when compared to the state of Ohio (21.8%). The Euclid Hospital Community has a higher proportion of residents aged 65+ (22.2%) when compared with the state of Ohio at 18.6%. Figure 4 shows further breakdown of age categories.

Figure 4: Population by Age Group: Hospital and State Comparisons

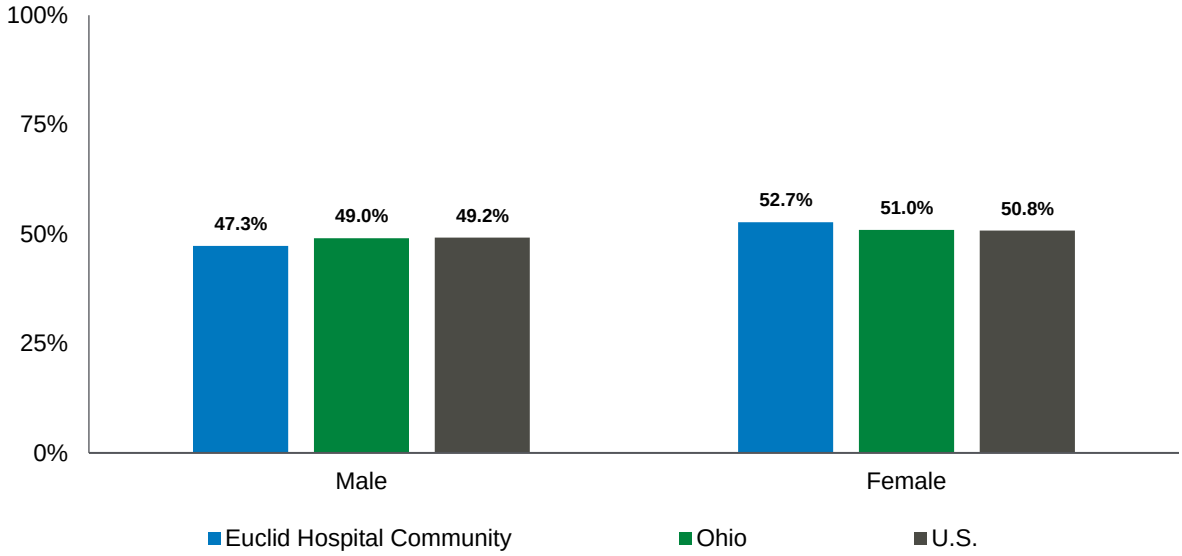


County and state values- Claritas Pop-Facts® (2022 population estimates)

Sex

Figure 5 shows the population of the Euclid Hospital Community by sex. Males comprise 47.3% of the population in the Euclid Hospital Community, which is less than both the Ohio (49.0%) and U.S. (49.2%) values. Females comprise 52.7% of the population in the Euclid Hospital Community, which is greater than Ohio (51.0%) and the U.S. (50.8%) values.

Figure 5: Population by Sex: Hospital, State, and U.S. Comparisons



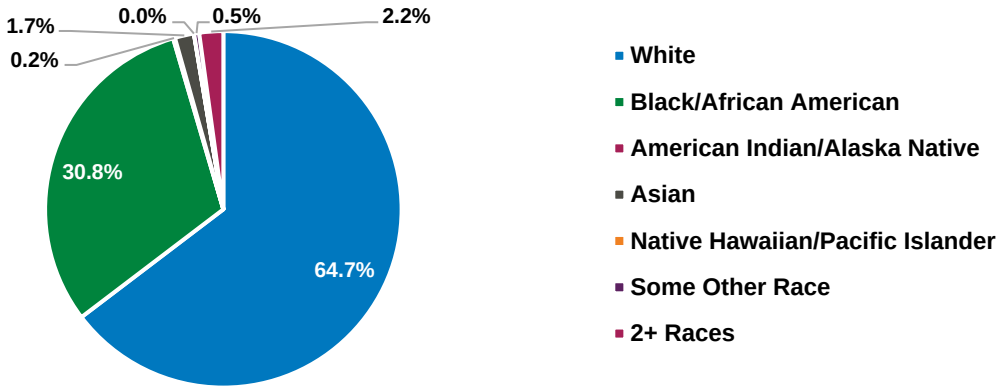
County and state values- Claritas Pop-Facts® (2022 population estimates) U.S. values taken from American Community Survey five-year (2015-2019) estimates

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 Euclid Hospital area shows 64.7% of the population identifying as White, as indicated in Figure 6. The proportion of Black/African American community members is the second largest of all races in the Euclid Hospital Community at 30.8%. Individuals who identified with other racial groups composed 4.5% of the Euclid Hospital Community.

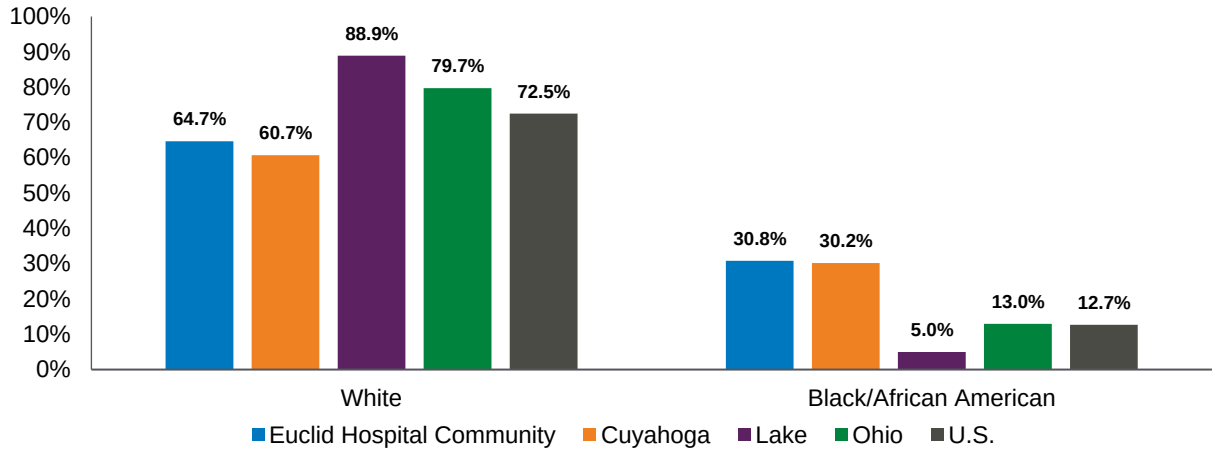
Figure 6: Population by Race: The Euclid Hospital Community



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

Community members who identify as White represent a lower proportion of the population in the Euclid Hospital Community (64.7%) compared to Ohio (79.7%) and the U.S. (72.5%). Black/African American community members represent a higher proportion of population in the Euclid Hospital Community (30.8%), compared to Ohio (13.0%) and the U.S. (12.7%). Almost one in three (30.8%) community members in Cuyahoga County identify as Black/African while 5.0% of Lake County community members identify as Black/African American (Figure 7).

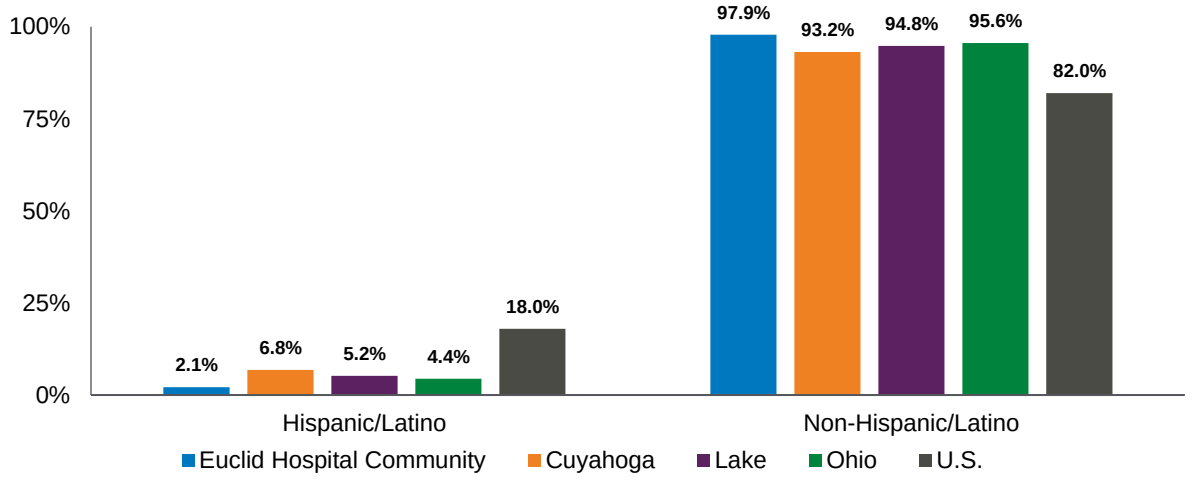
Figure 7: Population by Race: Hospital, County, State, and U.S. Comparisons



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 8, 2.1% of the population in the Euclid Hospital Community identify as Hispanic/Latino, which is lower compared to Ohio (4.4%) and much lower compared to the U.S. (18.0%). In Lake County 5.2% of the population identify as Hispanic/Latino compared to 6.8% in Cuyahoga County.

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



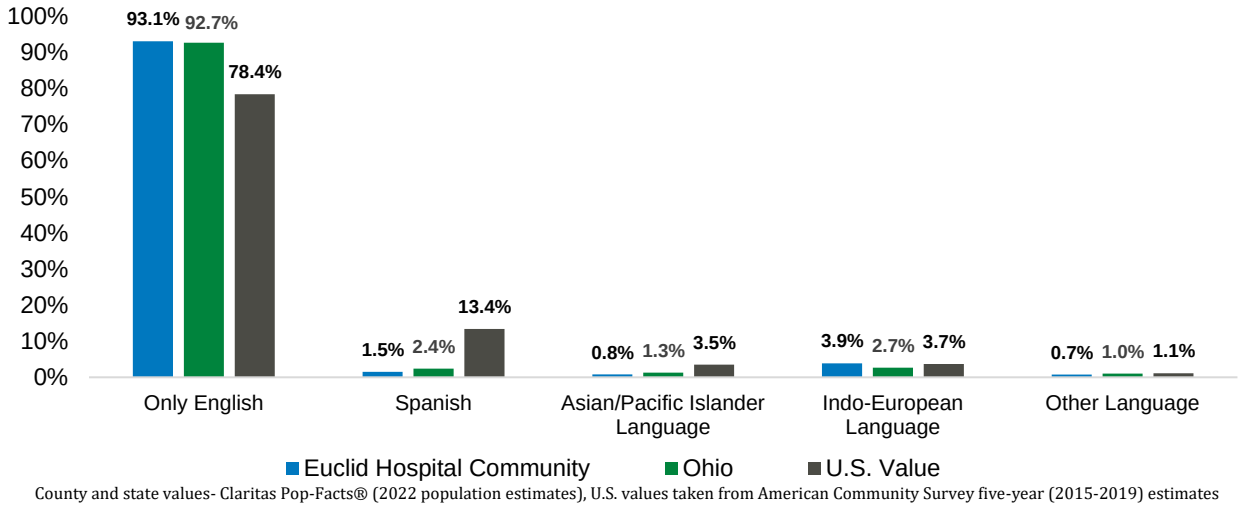
County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2015-2019) estimates

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 Euclid Hospital Community, 93.1% of the population age five and older speak only English at home, which is higher than both the state value of 92.7% and the national value of 78.4% (Figure 9). The data indicates that 1.5% of the population five and older in the Euclid Hospital Community speak Spanish, 0.8% speak an Asian or Pacific Islander language, 3.9% speak an Indo-European language, and 0.7% speak Other Languages at home.

Figure 9: Population 5+ by Language Spoken at Home: Hospital, State and U.S. Comparisons

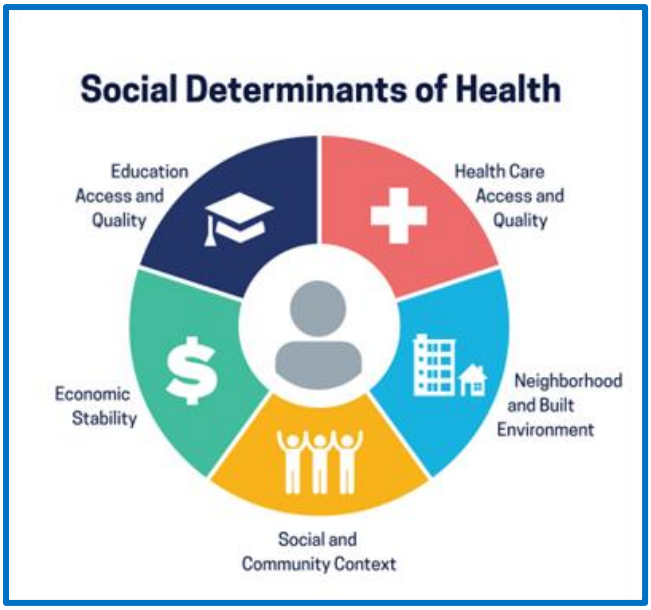


County and state values- Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2015-2019) estimates

Highlighted Demographics: Social & Economic Determinants of Health

This section explores the economic, environmental, and social determinants of health (SDOH) impacting the Euclid Hospital 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] Figure 10 shows the Healthy People 2030 grouping of Social Determinants of Health into five key domains.[12]

Figure 10: 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.

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

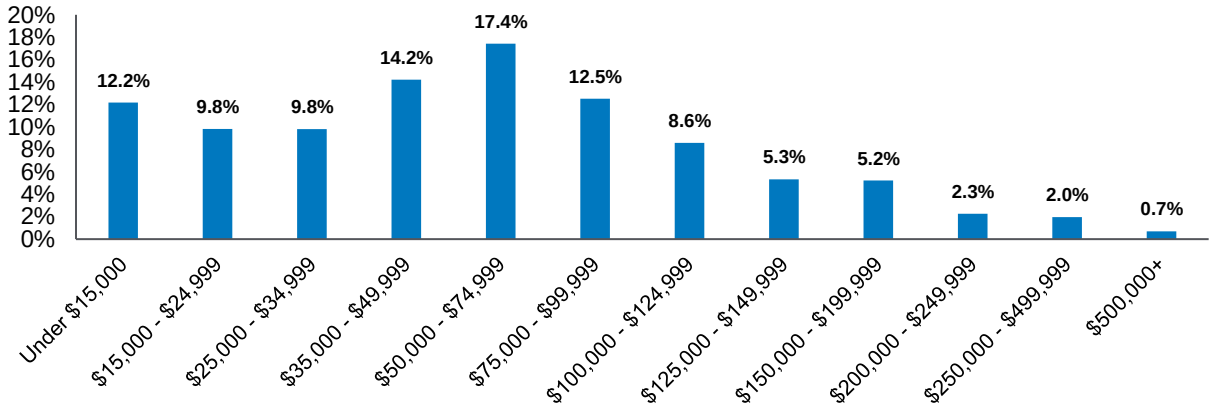
[12] Healthy People 2030, 2022. Social Determinants of Health Domains. https://health.gov/healthypeople/priority-areas/social-determinants-health

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 11 provides a breakdown of households by income in the Euclid Hospital Community Definition. A household income of $50,000 - $74,999 is shared by the largest proportion of households in the Euclid Hospital Community (17.4%). Households with an income of less than $15,000 make up 12.2% of households in the Euclid Hospital Community.

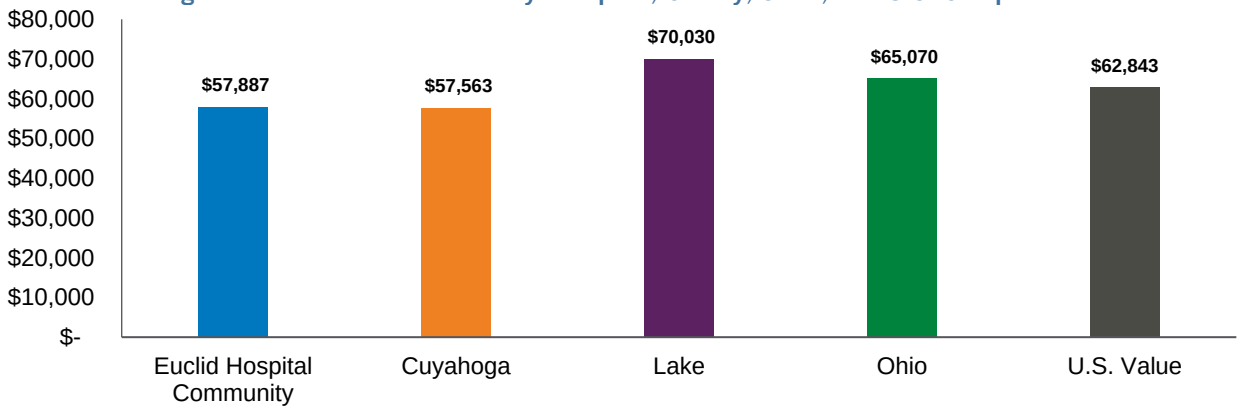
Figure 11: Households by Income: The Euclid Hospital Community



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

The median household income for the Euclid Hospital Community is $57,887, which is less than the state value of $65,070 and national value of $62,843 (Figure 12).

Figure 12: Household Income by: Hospital, County, State, and U.S. Comparisons

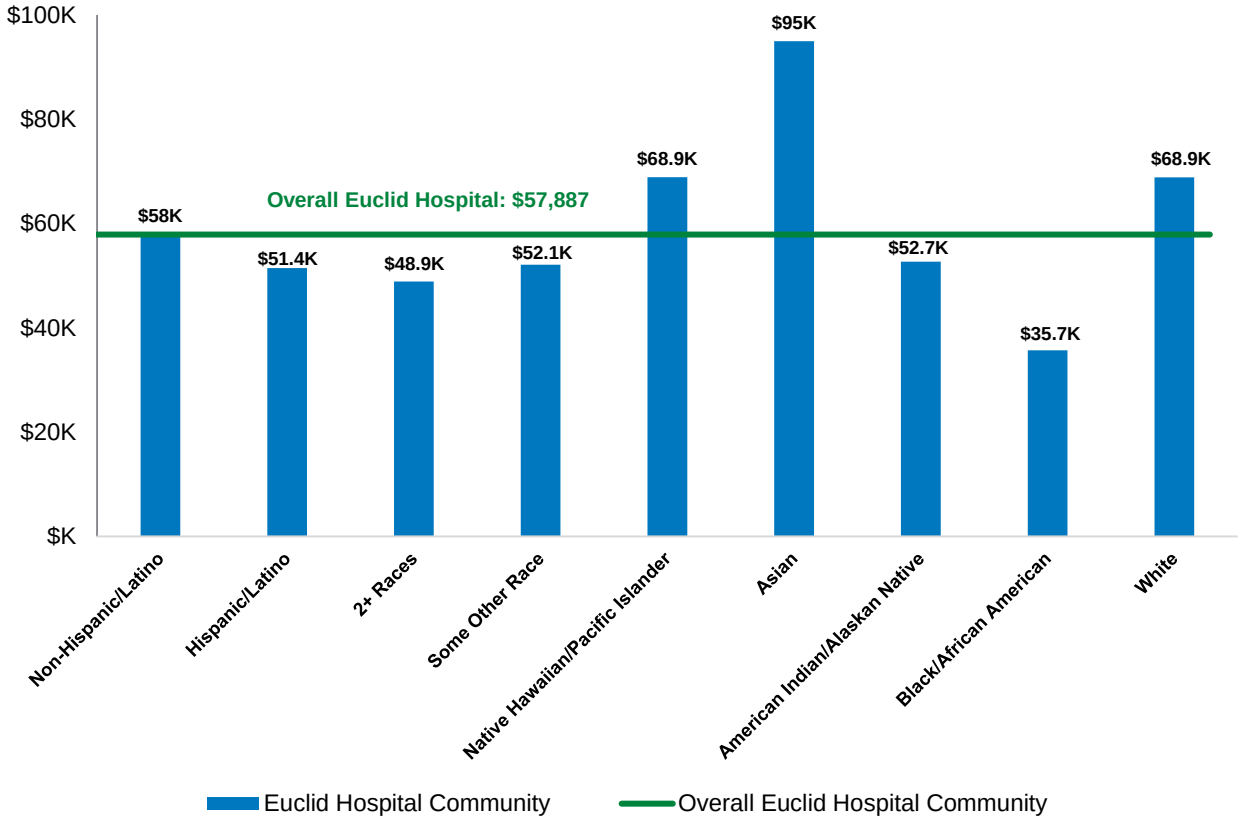


County and state values· Claritas Pop-Facts® (2022 population estimates), U.S. values taken from American Community Survey five-year (2015-2019) estimates

[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 13 shows the median household income by race and ethnicity. Four racial/ethnic groups – White, Asian, Native Hawaiian/Pacific Islander, 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 $35,698.

Figure 13: Median Household Income by Race/Ethnicity: The Euclid Hospital Community



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

Poverty

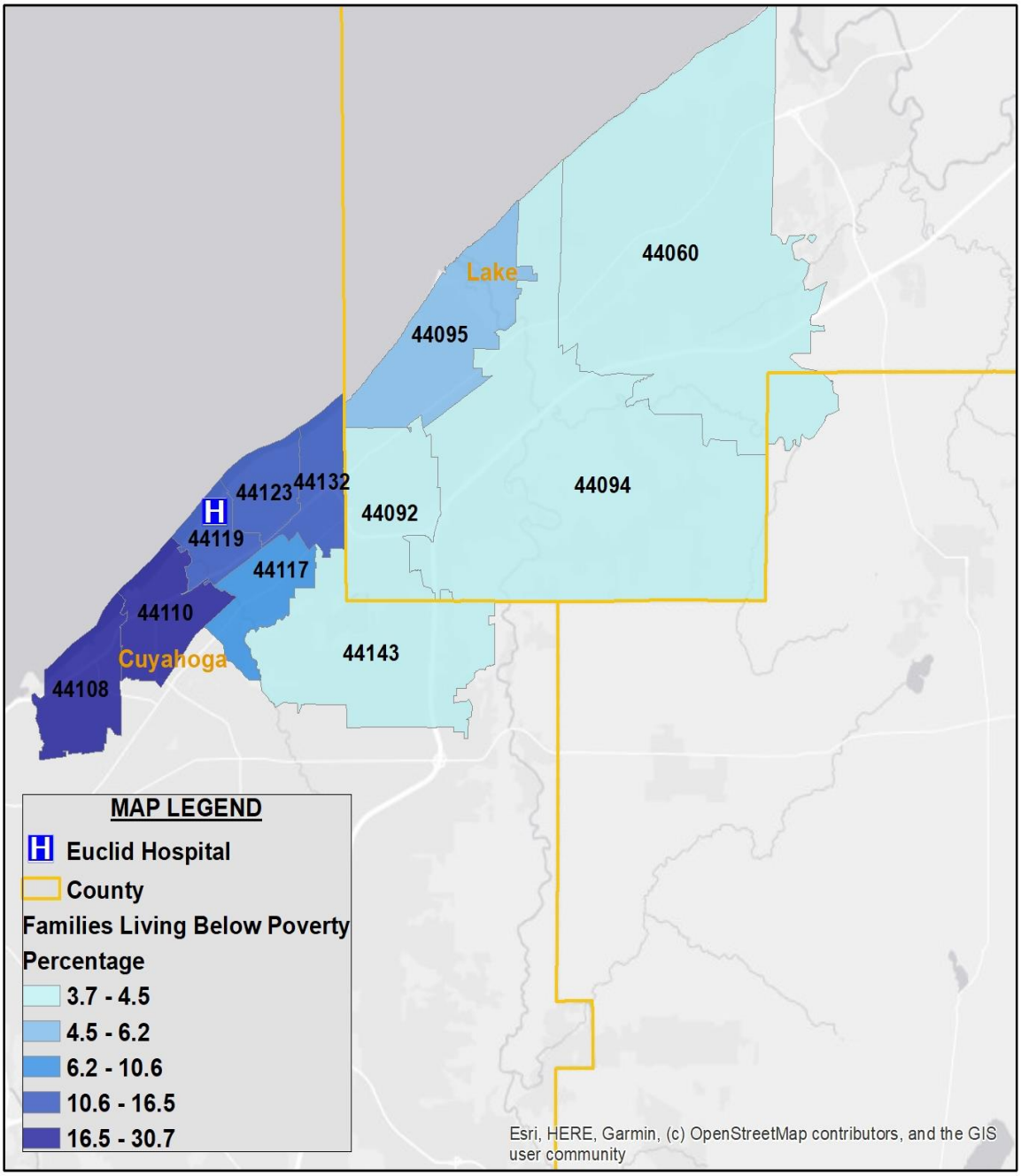
Federal poverty thresholds are set every year by the Census Bureau and vary by size of family and ages of family members. People living in poverty are less likely to have access to healthcare, healthy food, stable housing, and opportunities for physical activity. These disparities mean people living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

Figure 14 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 44110 (Cleveland) and 441108 (Cleveland) having the highest percentages at 30.8% and 24.2%, respectively. Overall, 9.6% of families in the Euclid Hospital Community live below the poverty level, which is similar to both the state value of 9.6%

[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

and the national value of 9.5%. The percentage of families living below poverty for each zip code in the Euclid Hospital Community is provided in Appendix C.

Figure 14: Families Living Below Poverty



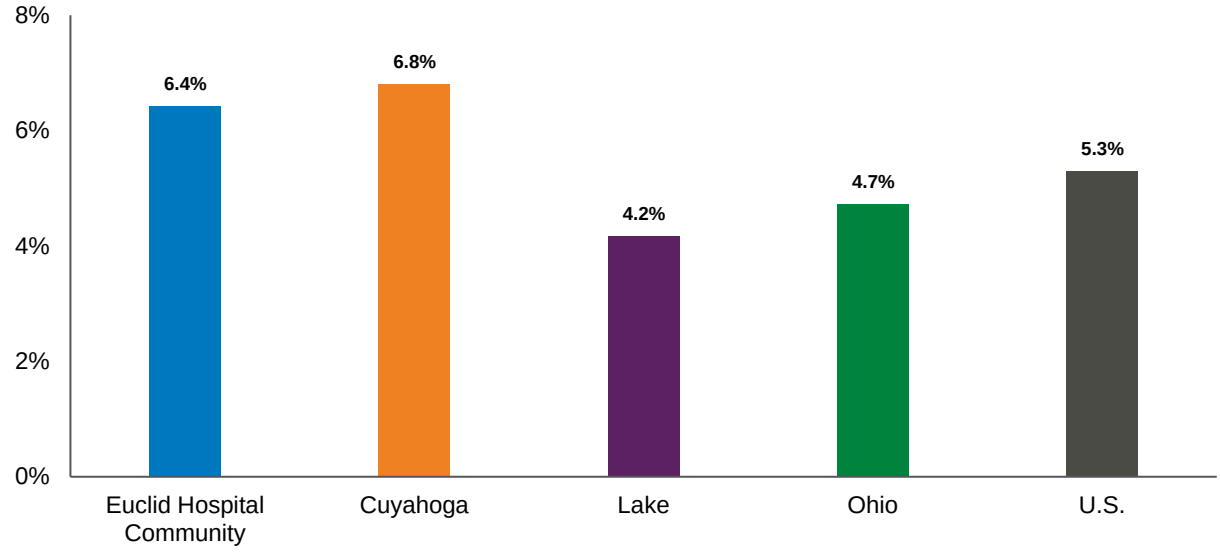
County values- Claritas Pop-Facts® (2022 population estimates)

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 15 shows the population aged 16 and over who are unemployed. The unemployment rate for the Euclid Hospital Community is 6.4%, which is higher than the state value of 4.7% and lower than the national value of 5.3%.

Figure 15: 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

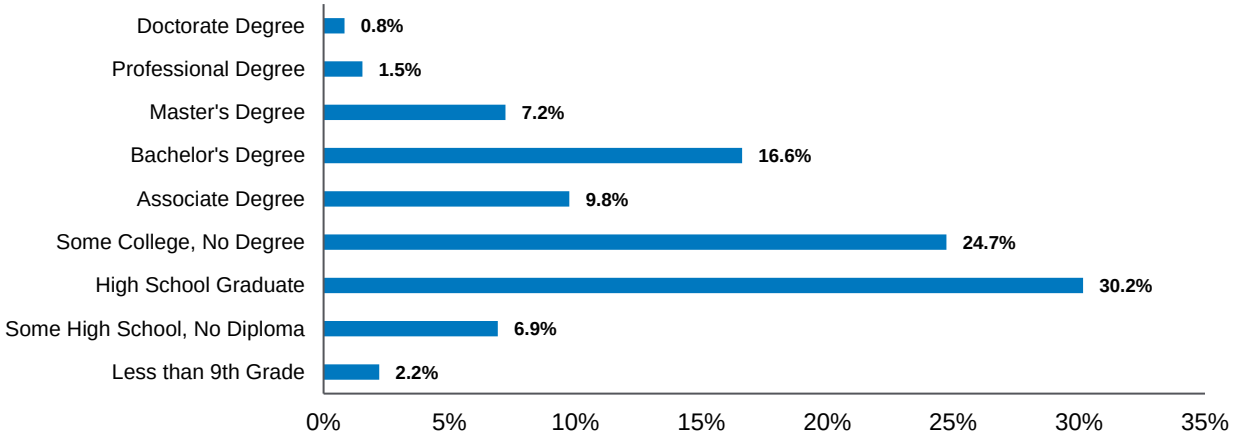
Education

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, to experience better health

[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

outcomes, and practice health-promoting behaviors.[16] Figure 16 shows the percentage of the population 25 years or older by educational attainment.

Figure 16: Population 25+ by Education Attainment: The Euclid Hospital Community

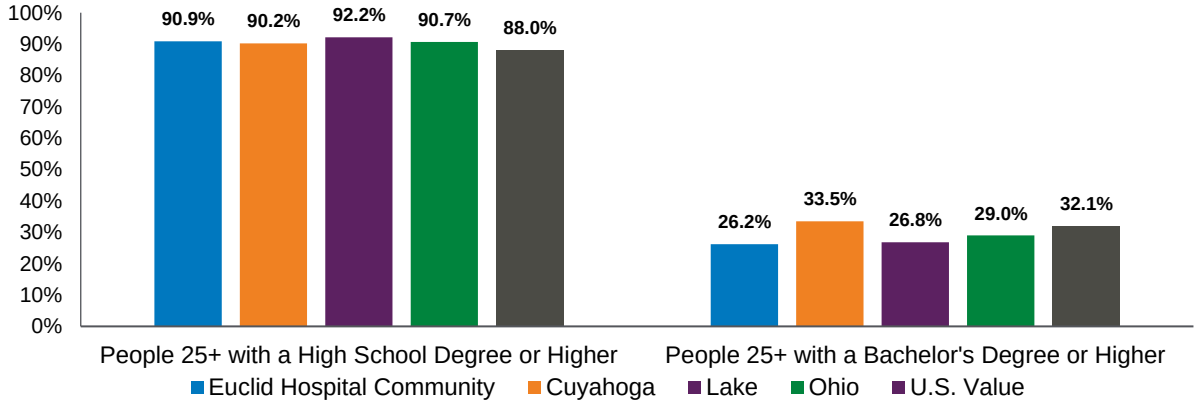


County values- Claritas Pop-Facts® (2022 population estimates)

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 17 shows the vast majority (90.9%) of Euclid Hospital Community residents 25 and older have a high school degree or higher, which is similar to the state value (90.7%) and higher than the national value (88.0%). More than one in four (26.2%) Euclid Hospital Community residents 25 and older have bachelor's degree or higher, which is less than the state of Ohio value (29.0%) and the U.S. value (32.1%) respectively.

Figure 17: 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

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

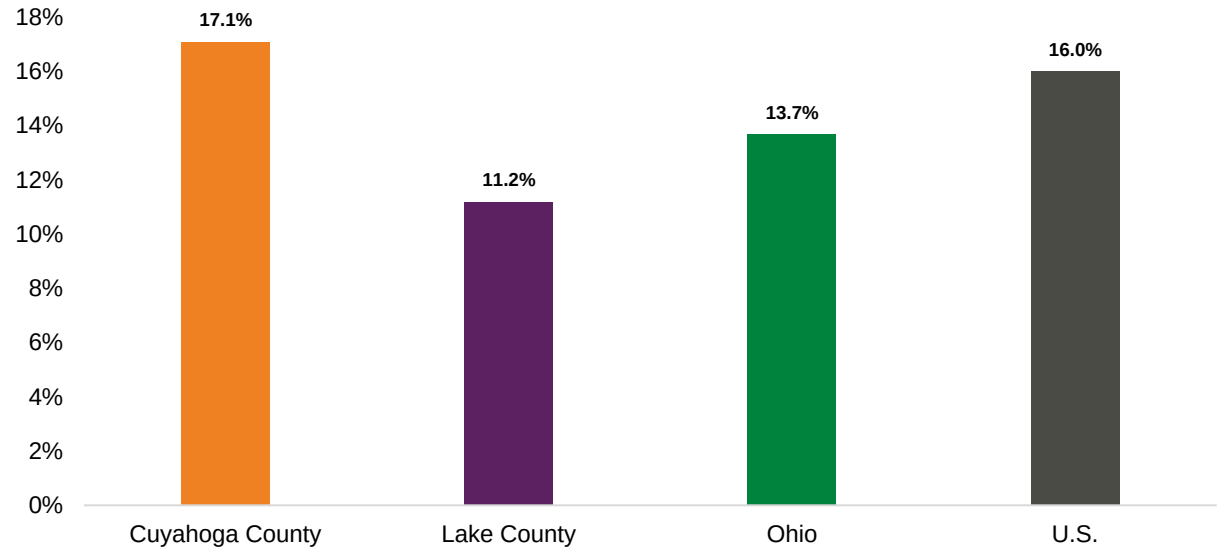
[17] U.S. Department of Health and Human Services, Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/social-determinants-health/literature-summaries/high-school-graduation

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 18 shows the percentage of houses with severe housing problems. This indicator measures the percentage of households with at least one of the following housing 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 18: Severe Housing Problems: County, State, And U.S. Comparisons



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

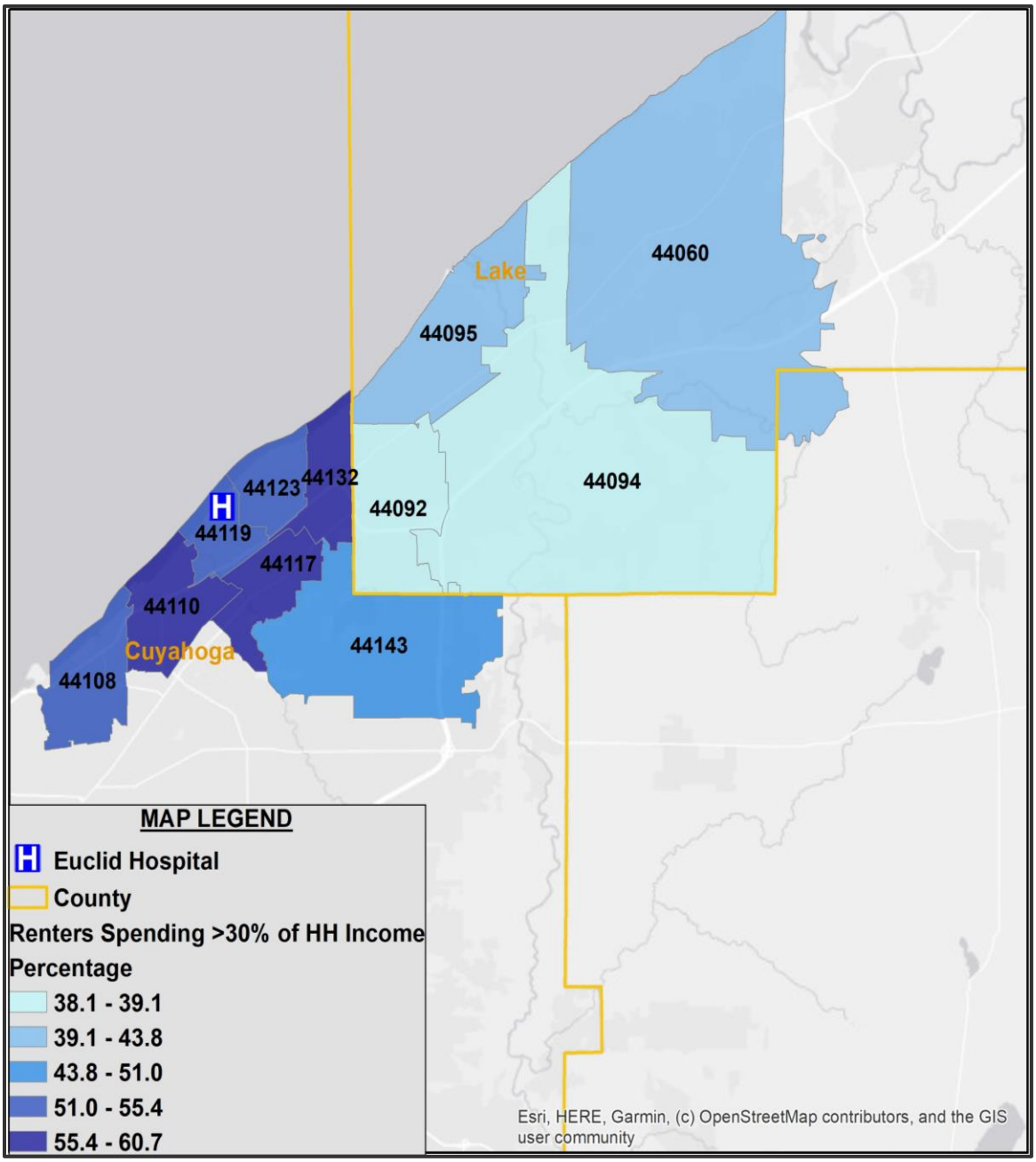
When families must spend a large portion of their income on housing, they may not have enough money to pay for things like healthy foods or healthcare. This is linked to increased stress, mental health problems, and an increased risk of disease.[19]

Figure 19 shows the percentage of renters who are spending 30% or more of their household income on rent.

[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

[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

Figure 19: Renters Spending 30% Or More Of Household Income on Rent



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

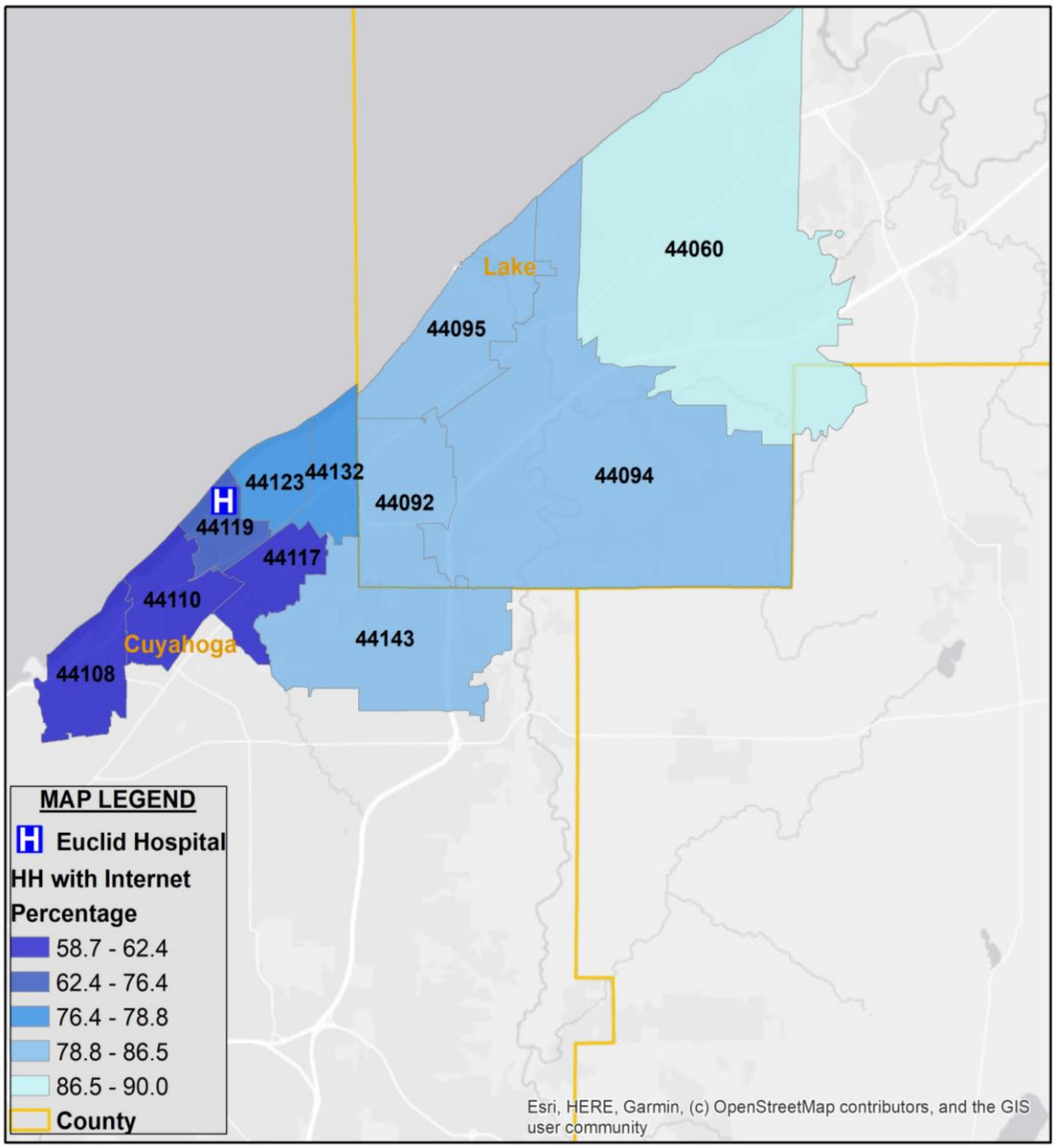
Neighborhood and Built Environment

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.[20]

[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

Internet access may also help individuals seek employment opportunities, conduct remote work, and participate in online educational activities.[20] Figure 20 shows the percentage of households that have an internet subscription. Zip code 44108 (Cleveland) has the least percentage of households with internet connection, represented by darkest shade of blue on the map.

Figure 20: Households with an Internet Subscription



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

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 is presented to show differences and distinctions by population groups. And a data variation within each population group may be as great as that between different groups. For instance, Asian or Asian and Pacific Islander persons encompasses individuals from over 40 different countries with very different languages, cultures, and histories in the U.S. 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 Euclid Hospital Community, based on the Index of Disparity.

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[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, Asian/Pacific Islander
Children Living Below Poverty Level	Black/African American, Hispanic/Latino, Other Race, Two or More Races
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	American Indian/Alaska Native, Black/African American, Hispanic/Latino
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	Asian, Native Hawaiian/Pacific Islander, Two or More Races
Young Children Living Below Poverty Level	Black/African American, Hispanic/Latino, Native Hawaiian/Pacific Islander, Other Race

The Index of Disparity analysis for Cuyahoga and Lake counties reveals that the Black/African American, Hispanic/Latino, American Indian/Alaskan Native, Two or More Races, Native Hawaiian/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, 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 by HIV/AIDS Prevalence Rate and Babies with Very Low Birth Weight. Hispanic/Latino and Other Race groups also have the highest rates of Persons without Health Insurance, compared to other races/ethnicities in the region.

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

Geographic Disparities

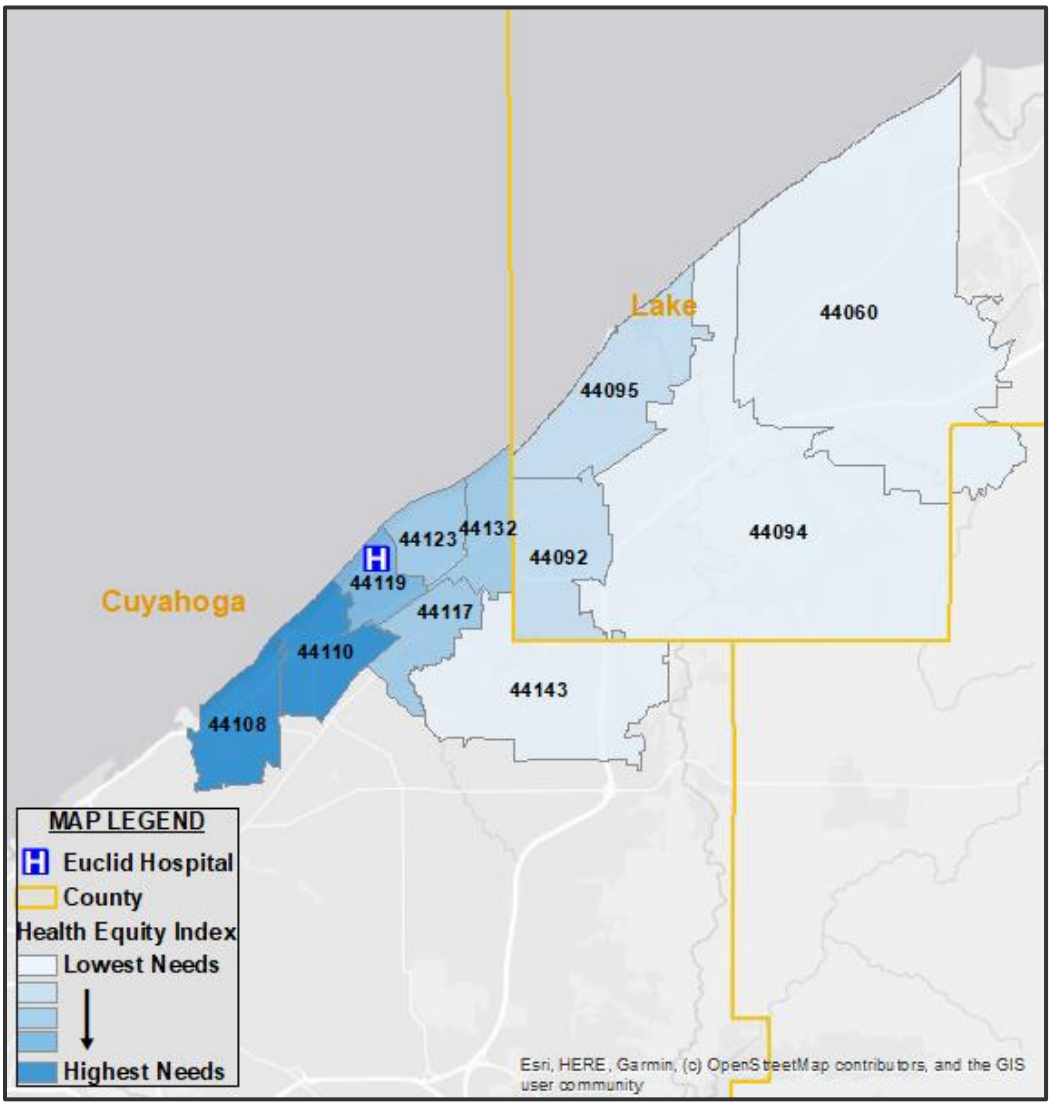
In addition to disparities by race, ethnicity, gender, and age, this assessment also identified specific zip codes/municipalities with differences in outcomes related to health

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 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 21. The following zip codes in the Euclid Hospital Community had the highest level of socioeconomic need (as indicated by the darkest shades of blue): 44108 and 44110 in Cuyahoga County. Appendix A provides the index values for each zip code.

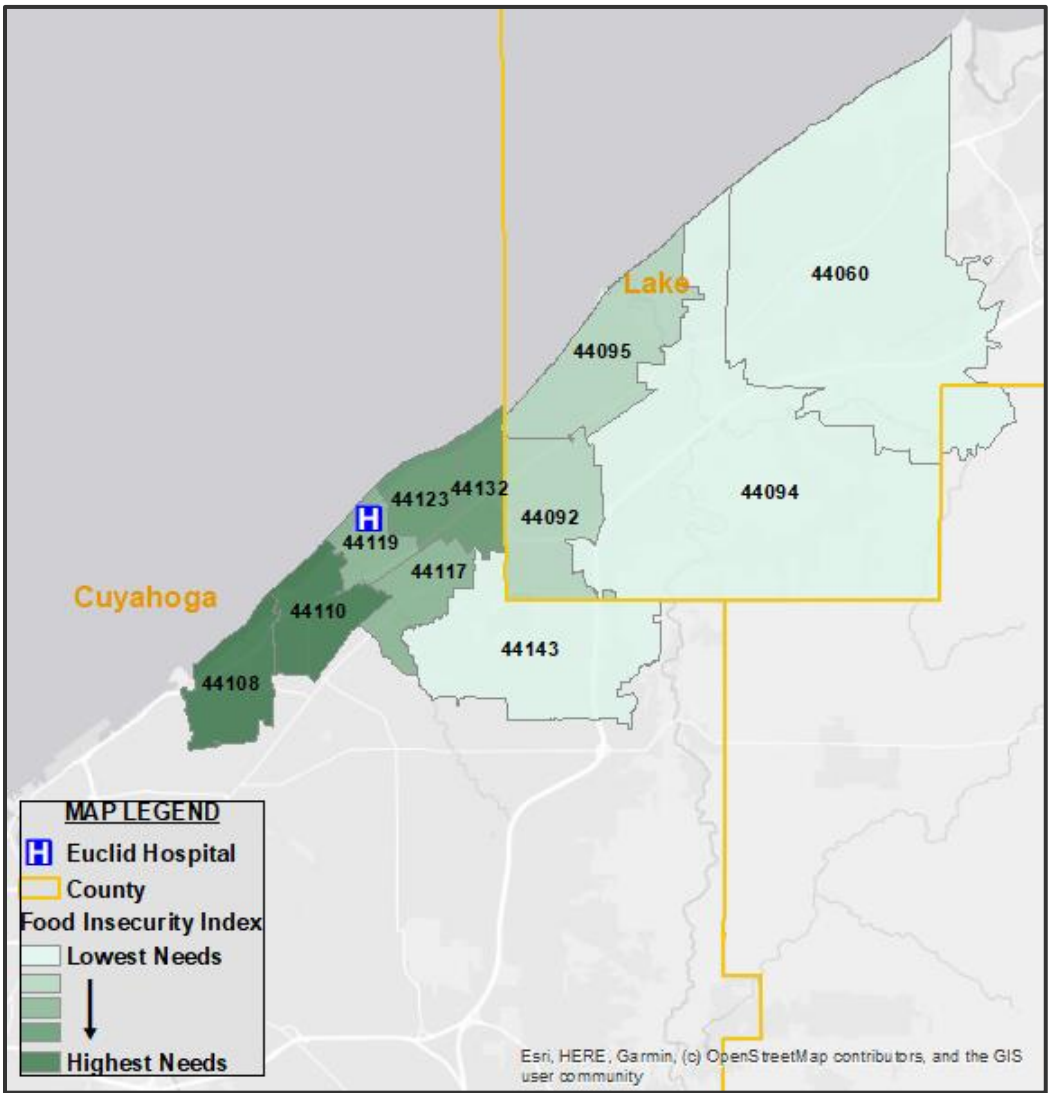
Figure 21: Health Equity Index



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 22. The following zip codes had the highest level of food insecurity (as indicated by the darkest shades of green): 44108 and 44110 in Cuyahoga County. Appendix A provides the index values for each zip code.

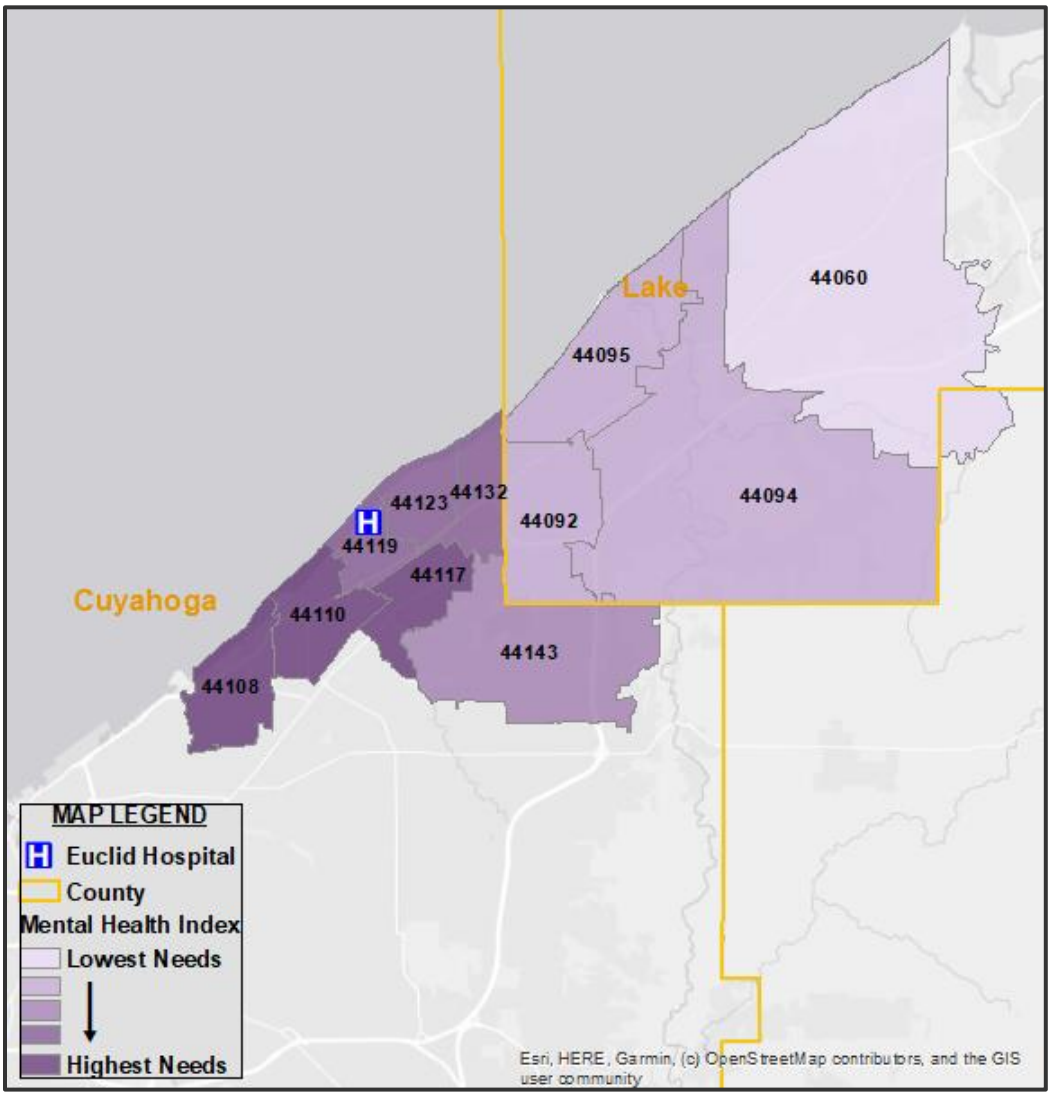
Figure 22: Food Insecurity Index



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 23. The following zip codes are estimated to have the highest need (as indicated by the darkest shades of purple): 44108, 44110, and 44117 in Cuyahoga County. Appendix A provides the index values for all zip codes within the Euclid Hospital Community.

Figure 23: 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 Euclid Hospital 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

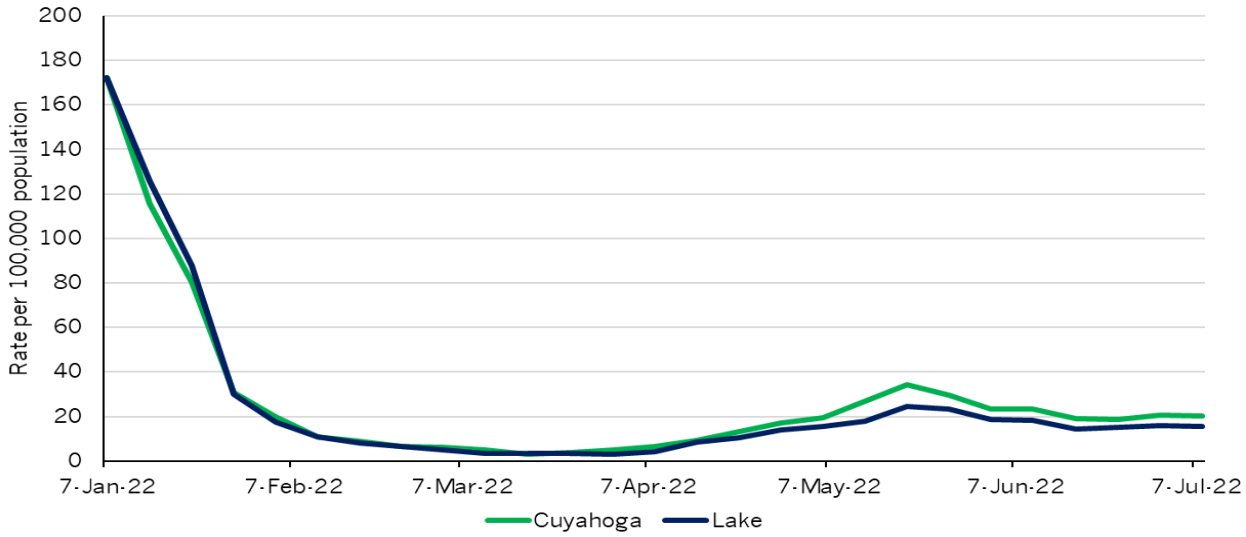
Community Input

Key stakeholder interviews and the Euclid Hospital 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 by County

Figure 24 shows the daily average COVID-19 case incidence rate for Cuyahoga and Lake counties from January 2022 through early July 2022. As shown, the incidence rate has declined since the beginning of 2022, although some small increases in incidence rates have occurred.

Figure 24: Daily Average COVID-19 Case Incidence Rate by County



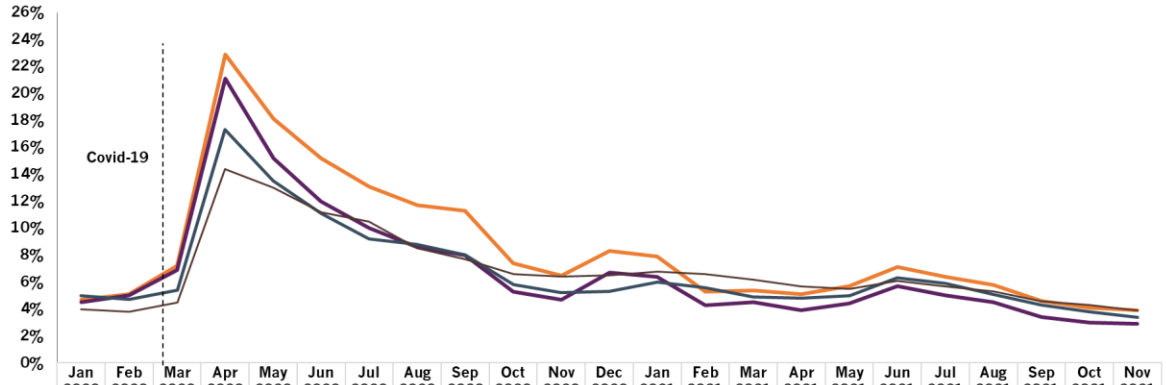
Vaccination Rates

As of June 2022, at least 65% of the population residing in counties within the Euclid Hospital Community Definition are fully vaccinated against COVID-19. Lake County has a vaccination rate of 66.2% and Cuyahoga County has a vaccination rate of 65.5%.

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 25 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 25: 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%
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%
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%

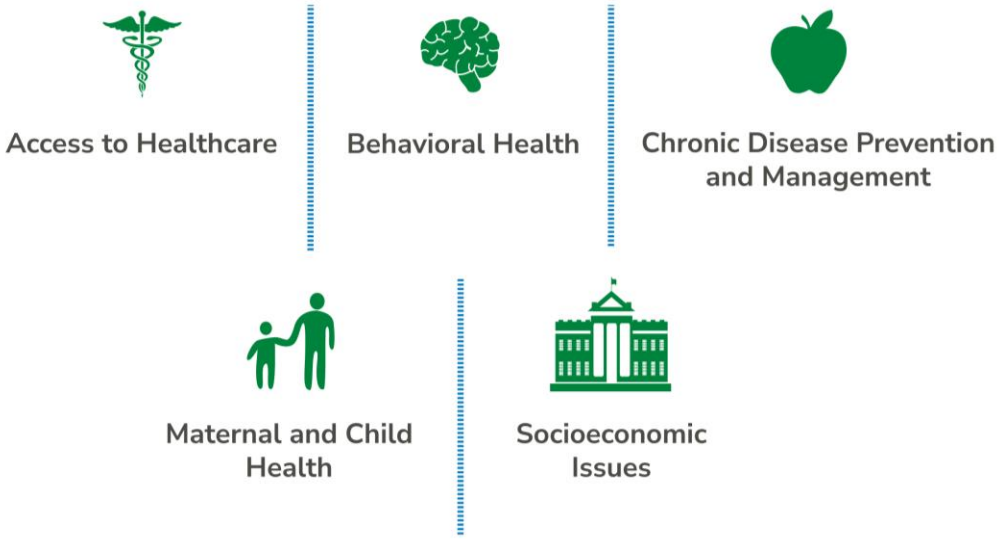
Synthesis and Prioritization

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.

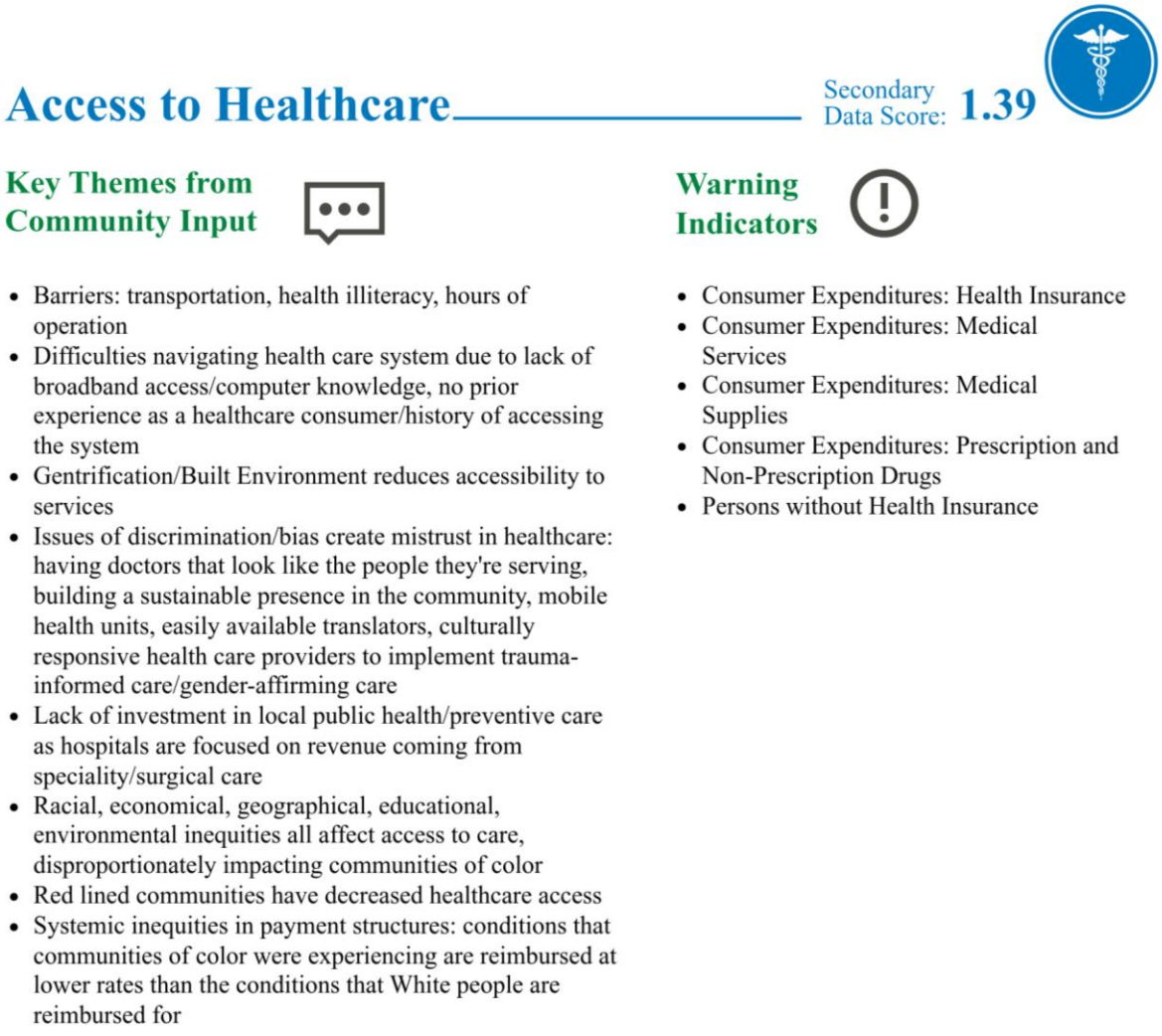
To gain a comprehensive understanding of the significant health needs for the Euclid Hospital Community, the findings from all three data sets were compared and studied simultaneously. The secondary data scores, community engagement session themes, and key stakeholder responses were considered equally 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. Seven 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 and Lake 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 26. Each prioritized health topic includes the key findings from secondary data, the community engagement session discussions and key stakeholder interviews.

Figure 26: 2022 Prioritized Health Needs



Prioritized Health Topic #1: Access to Healthcare



Primary Data: Key Stakeholder Interviews and Community Engagement Session

Access to Healthcare was discussed as a top health need by the Euclid Hospital Community Advisory Council members participating in the Community Engagement Session. Access, and access-related topics including health literacy, transportation and resource navigation, were trending themes throughout the course of the conversation. Poverty and the associated reduction in access to healthcare was identified as the most important health-related problem in the community. Specific barriers and challenges to accessing telehealth or virtual care include a lack of digital literacy, particularly among older adults and populations with low income that do not have regular access to technology or have slow or no internet access. In some instances, community members expressed fear of and aversion to technology—the multiple platforms and portals required to register for services—inhibited their access to increasingly technology-based health systems. Additonally, a lack of private transportation and more expansive public transportation options, as well as the rising costs of existing options, created barriers for

in-person care. Finally, lower income and older adult community members wondered what would happen to their jobs and homes if they were hospitalized for acute or chronic illness.

> I get referrals for residents that can't get transportation to go get their dialysis. They can't get to their doctor's appointment. There's a fear of going to the hospital because [patients think] "What's gonna happen with my rental unit?" "What if I stay in the hospital and then I get evicted? What's gonna happen there?" So they choose not to go to their doctor visits. I see a huge vacuum in Euclid for case management.
>
> - Community Engagement Session Participant

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

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

> 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

Secondary Data

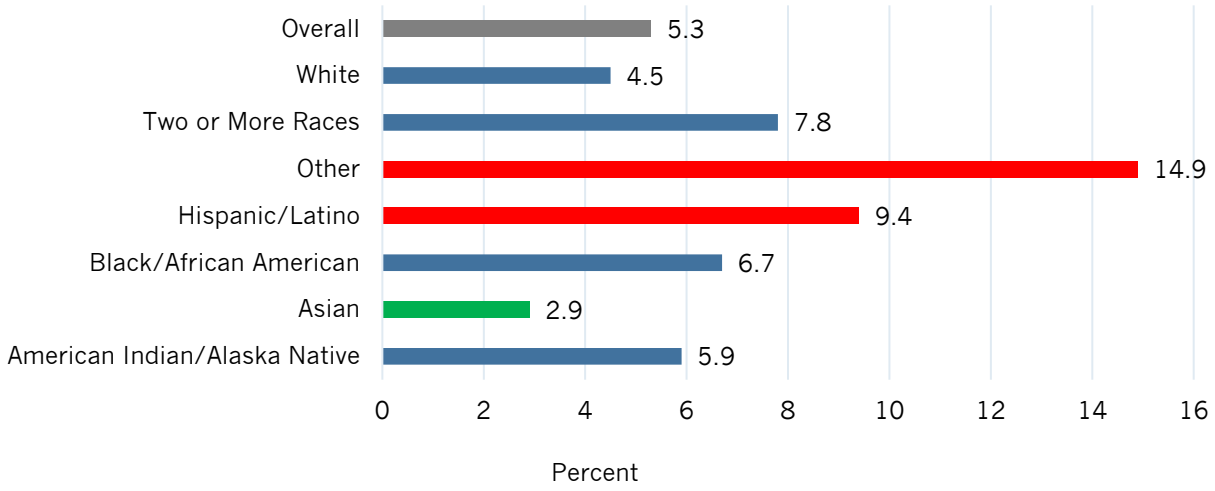
From the secondary data scoring results, Health Care Access & Quality ranked as the 11th highest scoring health need, with a score of 1.39. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized 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).

The average dollar amount per consumer unit for health insurance in Lake County is $4,910.2. This is higher than the average dollar amount spent on health insurance in the state of Ohio, where that amount is $4,371.7 dollars per consumer unit. A consumer unit is defined as a household or any person living in a college dormitory. Additionally, in Cuyahoga County, 89.8% of adults have health insurance, compared to 90.6% in the United States. 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. Figure 27 shows that residents identifying as Hispanic/Latino and Other Race are more likely to be without health insurance (9.4% and 14.9%, respectively. See red below.) compared to the overall population (5.3%).

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

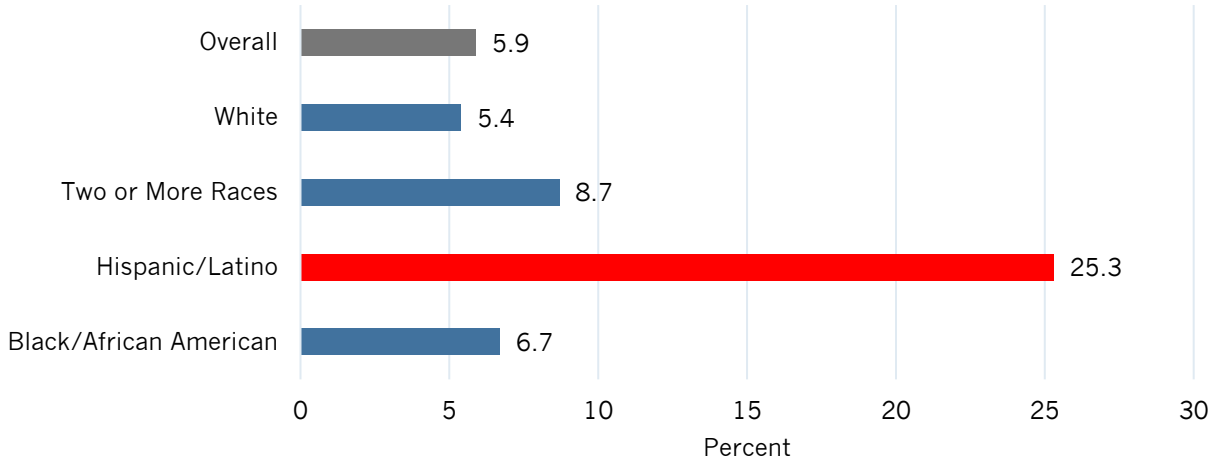
Figure 27. Persons without Health Insurance by Race/Ethnicity in Cuyahoga County



Source: American Community Survey, 2019

Similarly, as seen in Figure 28, in Lake County, persons identifying as Hispanic/Latino are much more likely to be without health insurance (25.3%, see red below.) compared to the overall population (5.9%).

Figure 28. Persons without Health Insurance by Race/Ethnicity in Lake County



Source: American Community Survey, 2019

Prioritized Health Topic #2: Behavioral Health

Behavioral Health: Mental Health

Secondary Data Score: 1.27

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 Euclid Hospital Community Advisory Council, representing a range of organizations within the community, who attended the Community Engagement session considered Mental Health the most important health problem in the community. One participant reported that a sign of an increase in mental health issues in the community was the use of emergency services for non-emergency needs. Stakeholders shared concerns about crime and violence, and its perceived association with unmet mental health needs. Challenges accessing healthcare, as described in the previous section of this report, also apply to mental healthcare. Council members advocated for promoting strong case managers to work toward individual solutions and assist with resource navigation. Additionally, they supported community programs that positively engage youth as key components programs to improve health in the community.

> We're seeing juveniles arrested repeatedly 6, 7, 8 times and then back out on the street without the system trying to understand, if they have mental health problems, elevated lead levels in their in their bloodstream, are homeless, being cared for, going to school, taking drugs, etc. I don't understand why preventive measures are not in place.
>
> - Community Engagement Session Participant

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, key informants shared that member of the LGBTQ community experience disproportionate mental health issues and are at a higher risk of suicide, particularly among those identifying as transgender. Participants also shared that the LGBTQ+ community has increased experiences with discrimination, bigotry and isolation. These were thought to contribute to increased mental health risks. Stakeholders recommended an increase in meaningful investment in community health programming.

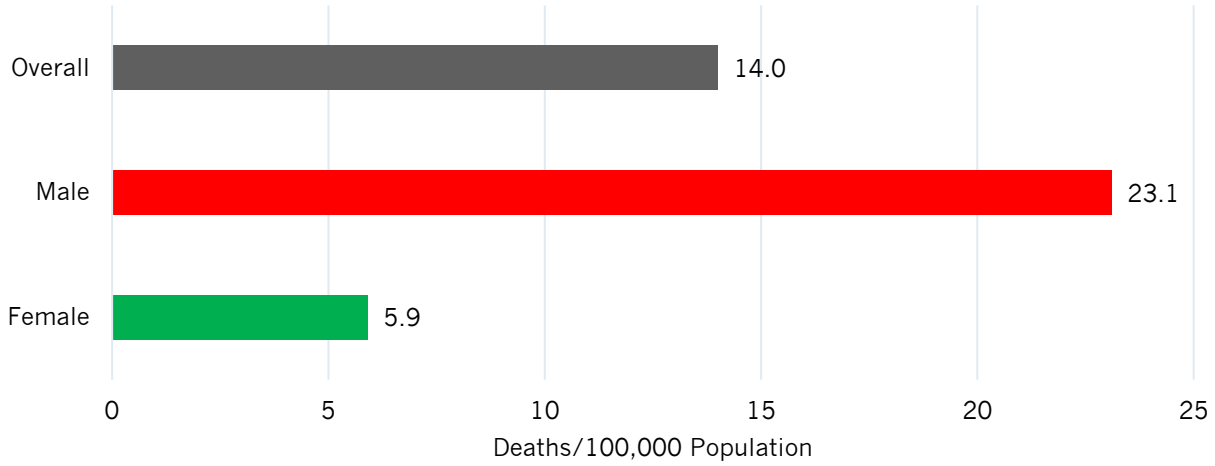
Secondary Data: Mental Health

From the secondary data scoring results, Mental Health & Mental Disorders had the 15th highest data score of all topic areas, with a score of 1.27. Further analysis was done to identify specific indicators of concern. 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. In Lake County, 19.2% of Medicare beneficiaries have been treated for depression. Over the past four years, both Lake and Cuyahoga counties have experienced an increase in Medicare beneficiaries receiving treatment for depression.

Disparities within the mental health topic area were also found for Euclid Hospital community counties. As seen in Figure 29, in Cuyahoga County, the age-adjusted death rate due to suicide for males is 23.1 deaths per 100,000 population (see red below), compared to 5.9 deaths per 100,000 for females (see green below).

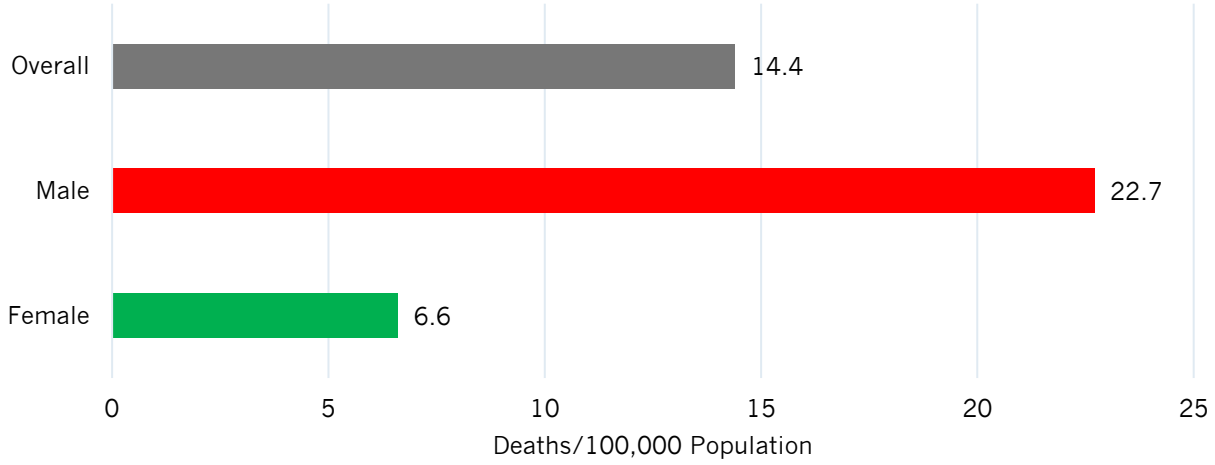
Figure 29. Age-Adjusted Death Rate due to Suicide by Gender in Cuyahoga County



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

Lake County also faces gender disparities in suicide deaths. The age-adjusted death rate due to suicide for males in Lake County is 22.7 deaths per 100,000 population (see red below), compared to 6.6 per 100,000 for females (Figure 30).

Figure 30. Age-Adjusted Death Rate due to Suicide by Gender in Lake 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 that is analyzed from four secondary data topics – Nutrition and Healthy Eating, Chronic Diseases, Older Adult Health and Cancer.

Primary Data: Key Stakeholder Interviews and Community Engagement Session

NUTRITION & HEALTHY EATING

Nutrition & Healthy Eating

Secondary Data Score: 1.39

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

Warning Indicators

- Consumer Expenditures: Fast Food Restaurants
- Consumer Expenditures: High Sugar Beverages
- Consumer Expenditures: High Sugar Foods

Participants in the Euclid Hospital Community Engagement Session described associations between poverty, food insecurity, healthy eating, and chronic diseases with a focus on diabetes in the community. 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 to.[26]

Key stakeholders revealed that access to healthy food was often limited by a lack of either public or private transportation. Participants shared that there were few or no grocery stores in some neighborhoods and existing stores were not within walking distance for some community members. Some key informants who were interviewed shared concerns that a lasting effect of redlining policies was limited access to grocery stores.

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[26] Centers for Disease Control and Prevention. National Center for Chronic Disease Prevention and Health Promotion. https://www.cdc.gov/chronicdisease/resources/publications/factsheets/nutrition.htm

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 expressed hope 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.

> 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

CHRONIC DISEASES

Chronic Diseases

Secondary Data Scores: 1.10 (Diabetes) 1.42 (Heart Disease & Stroke)

Key Themes from Community Input

- Addressing chronic conditions requires holistic solutions that target the social, economic, and environmental determinants of health
- Chronic diseases like diabetes and heart disease are disproportionately impacting low-income populations
- Heart disease, diabetes, obesity, cancer—all inherently tied to healthy food accessibility, built environment/walkability, safety, access to care
- Management of chronic diseases is more difficult for communities without access to high quality food leading to poor health outcomes
- Supporting the development of community health workers around diabetes prevention programs through grassroots approaches

Warning Indicators

- Adults 20+ with Diabetes
- Adults who Experienced a Stroke
- Age-Adjusted Death Rate due to Coronary Heart Disease
- Atrial Fibrillation: Medicare Population
- Heart Failure: Medicare Population
- Hyperlipidemia: Medicare Population
- Stroke: Medicare Population

The Euclid Hospital Community Engagement Session conversations described associations between sedentary lifestyles and chronic conditions, with an emphasis on diabetes prevalence in the community. First responders on the Community Advisory Council expressed concerns that individuals with low income and older adults had limited access to healthcare and used emergency services in lieu of primary care to manage hypertension, diabetes, and heart disease. Participants also discussed that older adults

require targeted health education programs and materials to prevent, identify and seek treatment for chronic conditions, including increasing physical activity.

> Sometimes they once they start experiencing a medical condition, they don't act on it right away. They either can't afford their prescriptions or they think that they'll try to self medicate or self prescribe and then they continue to become more ill and then it gets to a point where they're almost past the point of no return, and then they call us [the Euclid County Fire Department] and we find them very ill when if they would have had access sooner, this could have been prevented--especially in the senior community. We see a lot of hypertension, diabetes and coronary artery disease.
>
> - Community Engagement Session Participant

Key stakeholders discussed that environmental conditions could facilitate or hinder physical activity and healthy eating. For example, conditions including air quality, built environment and infrastructure, green space, safety/violence and walkability are factors that can impact a community's ability to exercise, play, and access healthy affordable food. Conditions such as hypertension, diabetes and coronary heart disease are all related to the quality of food community members have access to.[27] Thus, addressing chronic conditions like Diabetes and Heart Disease requires holistic solutions that target the social, economic and environmental factors mentioned above. Stakeholders reiterated that communities need to have opportunities to engage in healthy behaviors and have a healthy environment that allows for this. Finally, participants shared that chronic disease management is made more difficult when communities do not have access to high quality affordable food and places to exercise safely.

[27] Centers for Disease Control and Prevention. National Center for Chronic Disease Prevention and Health Promotion. https://www.cdc.gov/chronicdisease/resources/publications/factsheets/nutrition.htm

Older Adult Health

Secondary Data Score: 1.61

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
- Older adults ranked #2 most underserved population (tied with children and refugees)

Warning Indicators

- Adults with Arthritis
- Age-Adjusted Death Rate due to Falls
- Alzheimer's Disease or Dementia: Medicare Population
- Atrial Fibrillation: Medicare Population
- Cancer: Medicare Population
- Chronic Kidney Disease: Medicare Population
- Colon Cancer Screening
- Depression: Medicare Population
- Heart Failure: Medicare Population
- Hyperlipidemia: Medicare Population
- Osteoporosis: Medicare Population
- People 65+ Living Alone
- People 65+ with Low Access to a Grocery Store
- Rheumatoid Arthritis or Osteoarthritis: Medicare Population
- Stroke: Medicare Population

Euclid Hospital Community Engagement Session conversations described older adults as an underserved population in the community. Health and safety related concerns for this population range from mental health (loneliness and isolation) to chronic disease prevention and management (food insecurity, physical limitations preventing regular exercise, poor nutrition, diabetes, heart disease and hypertension). Overarching themes contributing to these poor health outcomes discussed included low access to healthcare and the impact of social determinants of health. Access to healthcare were described as impacted by limited health literacy, transportation challenges, and limited health system navigation skills. Chief among social determinants of health impacting the older adult population described were limited and low incomes as well as safety concerns in both neighborhoods where older adults live and inside their homes, especially as ageing impacts mobility and capacity to maintain a home independently.

Key stakeholders focused on older adults with lower incomes who are disproportionately affected by chronic conditions, access to healthy food and poor housing conditions—supporting the conclusions drawn and assertions made during the Euclid Hospital 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

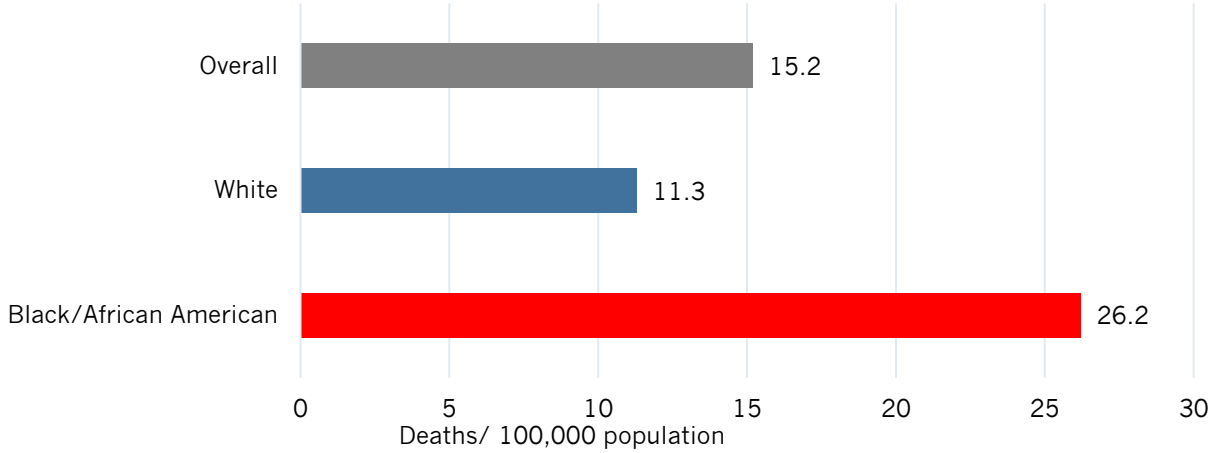
Nutrition & Healthy Eating had the 12th highest data score of all topic areas with a score of 1.39. The Older Adult Health topic area had the sixth highest score at 1.61 and the related Other Conditions health topic ranked fourth with a score of 1.76. Those indicators with high data scores (scoring at 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).

The Age-Adjusted Death Rate due to Prostate Cancer was the lowest performing indicator in Cuyahoga County with an indicator score of 2.72. The county also has a high incidence rate of prostate cancer, with Cuyahoga County performing in the worst 25% of counties in the state and nation.

In Lake County, the Age-Adjusted Death Rate due to Falls and Osteoporosis: Medicare Population were the worst performing indicators, both scoring a 2.92 out of a possible 3.00.

Disparities also exist within the Euclid Hospital Community when it comes to chronic diseases. Although not identified as a high disparity in the Euclid hospital community, Black/African American residents of Cuyahoga experience worse rates of Age-Adjusted Death Rate due to Kidney Disease than White residents. Figure 31 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 31. 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: 1.31

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

- Children with Low Access to a Grocery Store
- Consumer Expenditures: Childcare

Primary Data: Key Stakeholder Interviews and Community Engagement Session

Although not included in discussions during the Euclid Hospital Community Engagement Session, Maternal and Child Health has been a dominant part of community discussions across the Cleveland Clinic health system for multiple assessment cycles. High maternal and infant mortality rates across communities served by system hospitals have been of particular concern. Implementation strategies precipitated investments in community health focused on reducing maternal and infant mortality.

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. Participants shared that during the COVID-19 pandemic, longer periods of time spent indoors increased exposures and worsened lead related incidents and outcomes.

Stakeholders also noted that there is an opportunity for the payer community to cover food for pregnant people experiencing food insecurity as a way 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 should be based on need. Stakeholders held that in the city of Cleveland and in broader 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 disparities.

Participants also shared their concerns that children across the service area experienced learning loss during the pandemic as classrooms went remote. 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, key informants also shared that mental and behavioral health challenges are impacting children at increasingly younger ages. Social isolation during the pandemic also prevented parents from seeking primary care services for their children, including immunizations and well visits. Finally, key stakeholders expressed those 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 14th with a score of 1.31. 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).

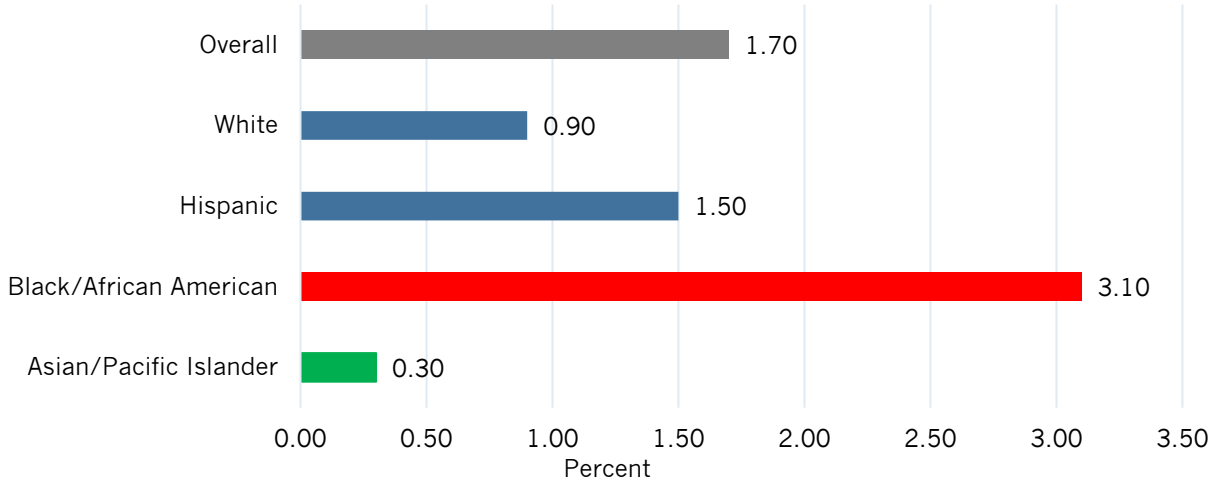
Consumer Expenditures: Childcare is the worst-performing indicator in Lake County, where residents spend an average of $315 per consumer unit. A consumer unit is defined as a household or any person living in a college dormitory. This data captures childcare, day care, nursery school, preschool, and non-institutional day camps.[28] 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.[29]

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

[28] Claritas Consumer Buying Power
[29] Center for American Progress, 2021

Very Low Birth Weight, as shown in Figure 32, while Asian/Pacific Islander residents see a much lower rate (0.3, see green below).

Figure 32. 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: **2.06**

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 Motor Vehicle Collisions
- Age-Adjusted Death Rate due to Unintentional Injuries
- Age-Adjusted Death Rate due to Unintentional Poisonings
- Annual Ozone Air Quality
- Asthma: Medicare Population
- Children with Low Access to a Grocery Store
- Death Rate due to Drug Poisoning
- Farmers Market Density
- Fast Food Restaurant Density
- Low-Income and Low Access to a Grocery Store
- Number of Extreme Precipitation Days
- People 65+ with Low Access to a Grocery Store
- Physical Environment Ranking
- SNAP Certified Stores
- WIC Certified Stores

Primary Data: Key Stakeholder Interviews and Community Engagement Session

During the Euclid Hospital Community Engagement Session youth violence was also top of mind. First responder Community Advisory Council members participating in the session noted a marked increase in all forms of violence in recent years citing challenges with family disputes, unstable home environments, unmet mental health needs, and unstable economic conditions as contributing factors. Stakeholders shared that each of these factors were exacerbated by COVID-19. They also shared that subsequent inflation and other market forces strained the few existing resources in the county dedicated to managing the emerging crisis of gun violence as well as other forms of violence.

> One of the things that I've noticed throughout my 22 year career with the city is the increase increases in youth violence. Everything from blunt trauma to penetrating trauma. And we're actually starting to see more violent crimes committed by young adults that require our services because someone's been injured.
>
> - Community Engagement Session Participant

Key stakeholders couched discussions around specific health needs in the context of intergenerational experiences of poverty, poor housing conditions, and historical redlining. They shared that there is generally a lack of resources for individuals and communities to create healthy conditions for people to live, work and play. Some participants also shared their concerns that transgender patients were experiencing higher rates of violence.

> 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

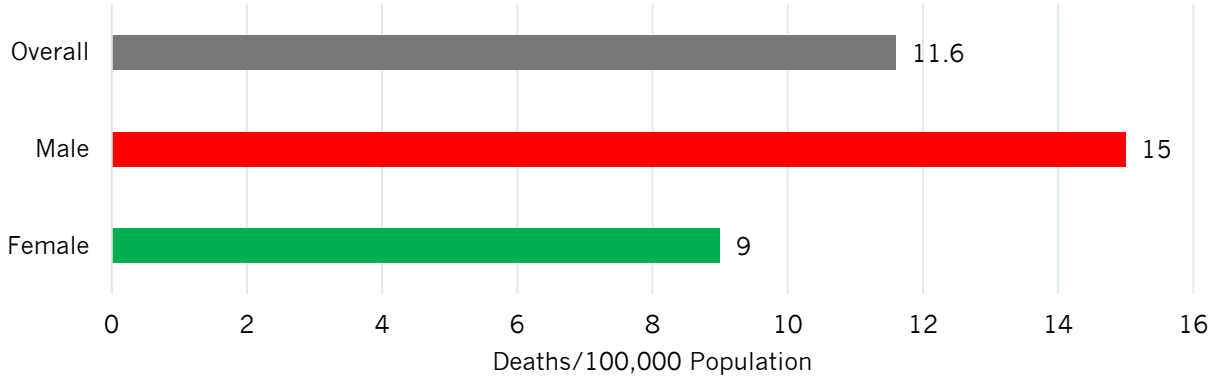
Prevention & Safety ranked second among all health topics with a score of 2.06. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (scoring at or above the threshold of 1.50) were categorized as indicators of concern and can be found in Appendix 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).

Age-Adjusted Death Rate due to Falls ranks poorly in Lake County with 17.3 deaths per 100,000 population. For this indicator, Lake County falls in the worst 25% of Ohio and U.S. counties and the rate is increasing significantly.

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.

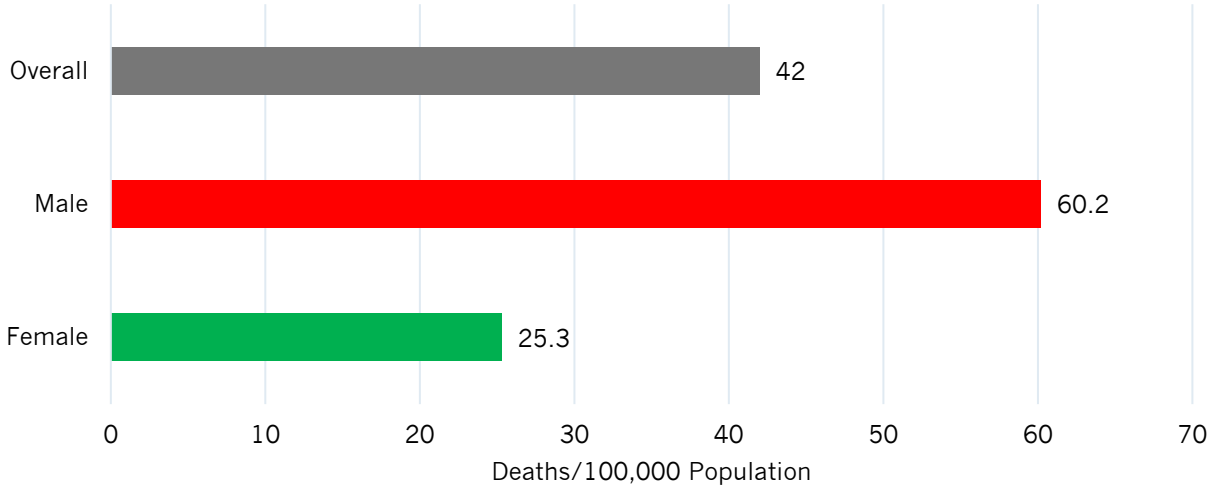
In Cuyahoga County, disparities exist for males in the following indicators: Age-Adjusted Death Rate due to Falls, Age-Adjusted Death Rate due to Unintentional Poisonings, and Age-Adjusted Death Rate due to Unintentional Injuries as seen in Figures 33, 34 and 35.

Figure 33. Age-Adjusted Death Rate due to Falls by Gender in Cuyahoga County



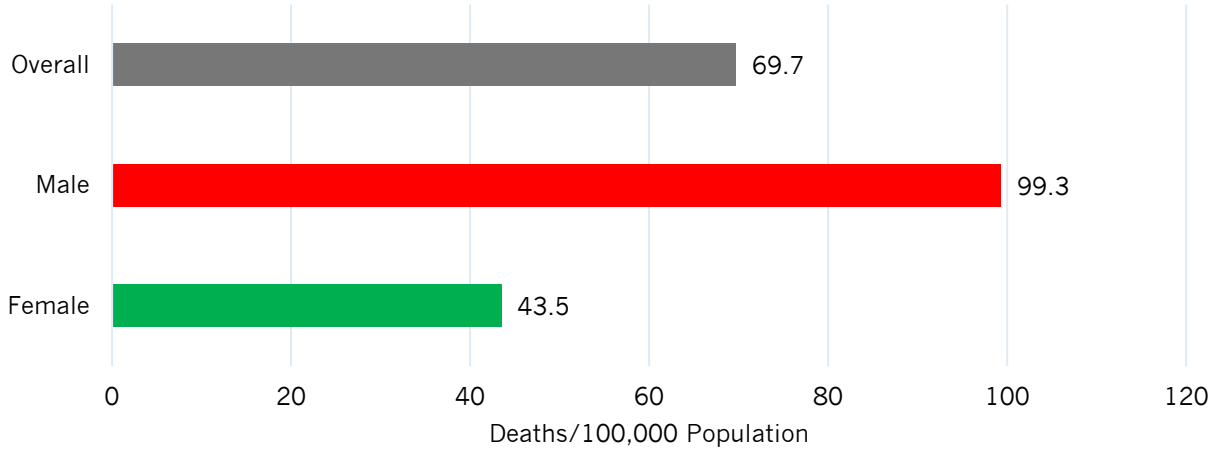
Source: Centers for Disease Control and Prevention, 2017-2019

Figure 34. Age-Adjusted Death Rate due to Unintentional Poisonings by Gender in Cuyahoga County



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

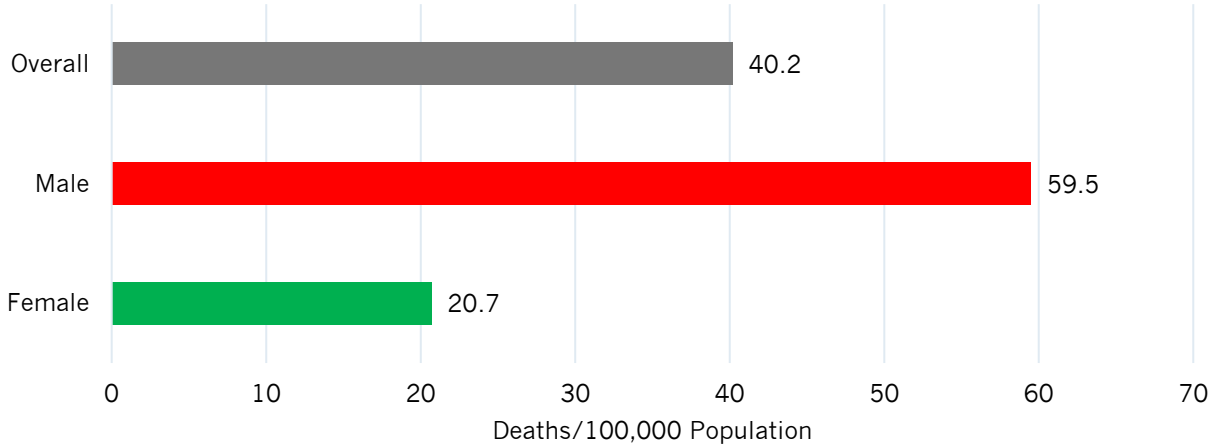
Figure 35. Age-Adjusted Death Rate due to Unintentional Injuries by Gender in Cuyahoga County



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

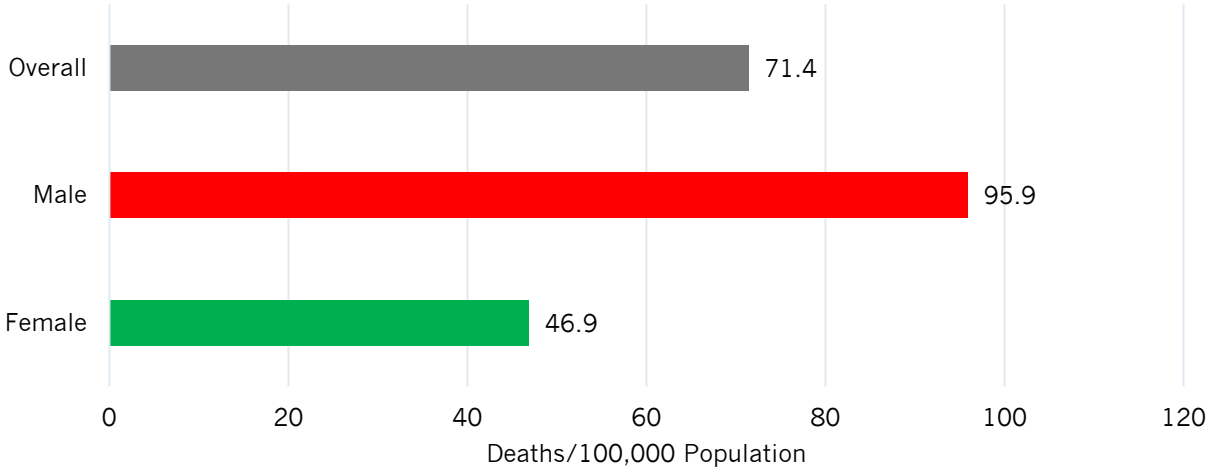
Similarly, in Lake County, disparities exist for males in the following indicators: Age-Adjusted Death Rate due to Unintentional Poisonings and Age-Adjusted Death Rate due to Unintentional Injuries as seen in Figures 36 and 37.

Figure 36. Age-Adjusted Death Rate due to Unintentional Poisonings by Gender in Lake County



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

Figure 37. Age-Adjusted Death Rate due to Unintentional Injuries by Gender in Lake County



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

2022 Euclid Hospital CHNA Alignment

The final prioritized health needs from this 2022 Euclid Hospital 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 Euclid Hospital CHNA priority areas. The check mark icon in Figure 38 indicates areas of alignment.

Figure 38. Euclid Hospital CHNA Alignment

2019 Ohio SHA/SHIP	2019 Euclid Hospital CHNA	2022 Euclid Hospital 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

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 Community Health Needs Assessment (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 and included data for Cuyahoga and Lake counties. The findings from each data source were then synthesized and organized by health topic to present a comprehensive overview of health needs in the Euclid Hospital 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 Euclid Hospital Community Health Needs Assessment:

- American Community Survey
- American Lung Association
- Annie E. Casey Foundation
- CDC - PLACES
- Centers for Disease Control and Prevention (CDC)
- 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

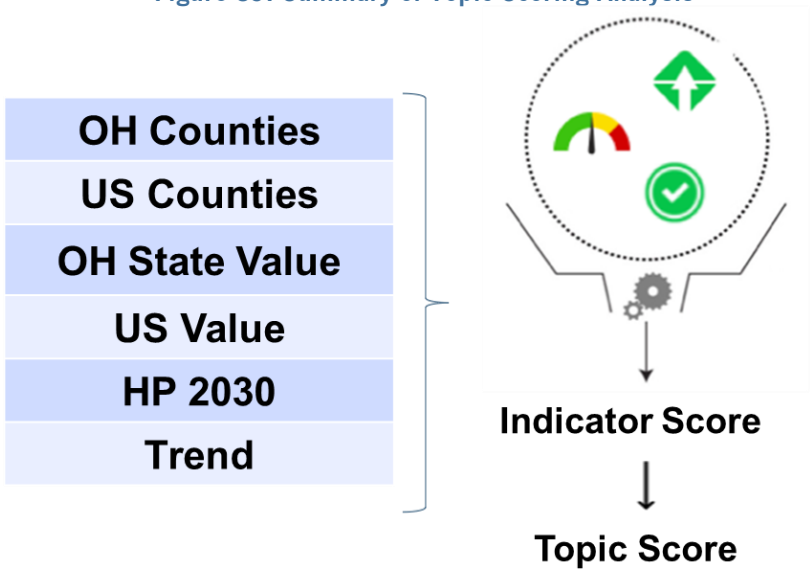
- Ohio Department of Public Safety, Office of Criminal Justice Services
- Ohio Public Health Information Warehouse
- Ohio Secretary of State
- U.S. Bureau of Labor Statistics
- U.S. Census - County Business Patterns
- U.S. Department of Agriculture - Food Environment Atlas
- U.S. Environmental Protection Agency
- United For ALICE

Secondary data used for this assessment were collected and analyzed from Conduent Healthy Community Institute'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

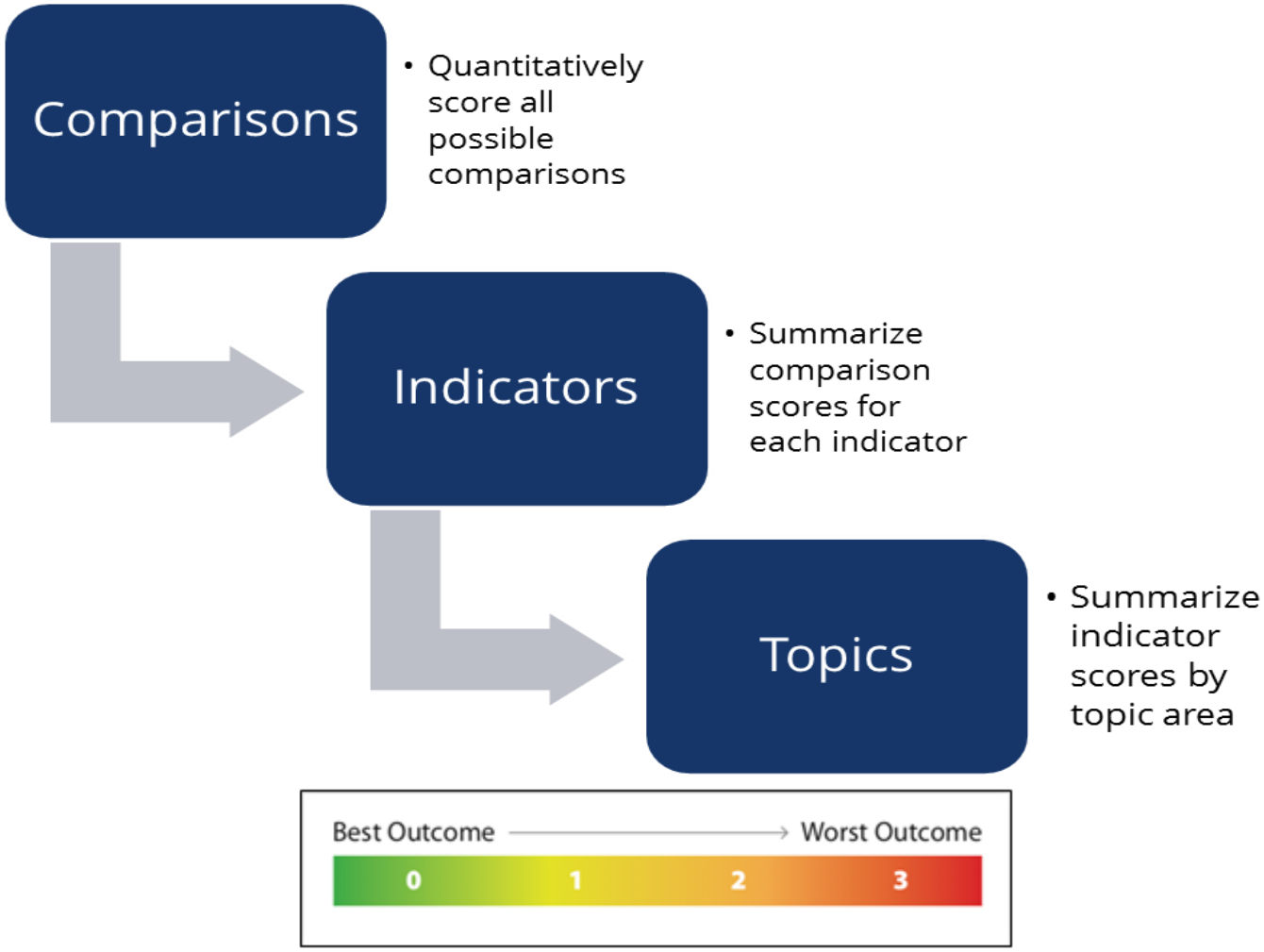
HCI's Data Scoring Tool (Figure 39) was used to systematically summarize multiple comparisons in order to rank indicators based on highest need. This analysis was completed at the county level. For each indicator, the community value was compared to a distribution of Ohio and US counties, state and national 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 39: 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 separately for the two counties within the Euclid Hospital Community: Cuyahoga and Lake counties. To calculate the overall highest needs topic area scores, an average was taken for each topic area across the two counties. Each county's values were weighted the same. More details about topics scores and the average score for the Euclid Hospital 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 2 shows the health and quality of life topic scoring results for the Euclid Hospital Community, ranked in order of highest need. Medications & Prescriptions scored as the poorest performing topic area with a score of 2.11, followed by Prevention & Safety with a score of 2.06. Topics that received a score of 1.50 or higher were considered a significant health need. Nine topics scored at or above the threshold. Topic areas with fewer than three indicators were considered a data gap.

Table 2: Top Secondary Data Health Needs

Top Secondary Data Health Needs
Medications & Prescriptions
Prevention & Safety
Alcohol & Drug Use
Other Conditions
Cancer
Older Adults
Women's 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.

Table 3 below lists each zip code within the Euclid Hospital Community and their respective HEI, FII, and MHI values.

Table 3: HEI, FII and MHI Values for Zip Codes within the Euclid Hospital Community

Zip Code	HEI Value	FII Value	MHI Value
44060	17.3	25	61.9
44092	32.1	45.4	75.2
44094	17	27.1	70.3
44095	42.7	43.5	75
44108	98.8	97.6	100
44110	98.6	98.4	99.9
44117	80	88	99.2
44119	85.3	86	97.2
44123	79.4	89.4	98.3
44132	81.2	91.6	98.2
44143	20	25.4	89

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

Euclid Hospital invited members of the hospital Community Advisory Council (CAC) to participate in a community engagement session. The session was held virtually on June 8, 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 40 shows the results from analysis of inputs collected from these tools.

Figure 40: Community Engagement Session Findings

Key Stakeholder Interviews Methodology and Results

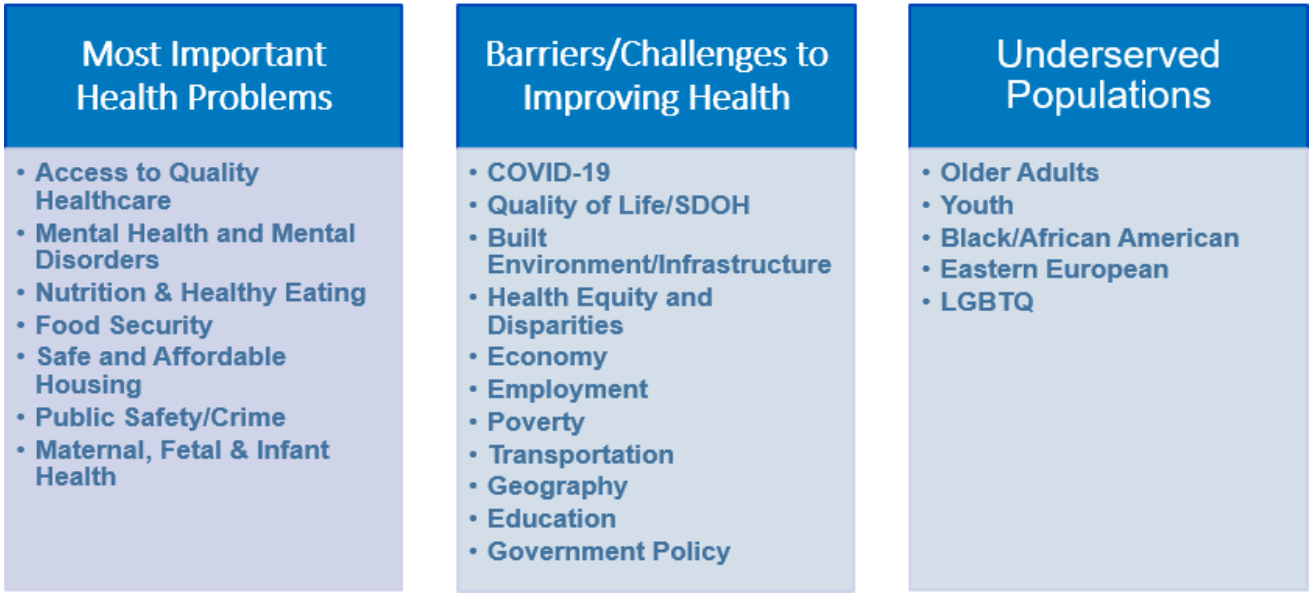
The project team also captured detailed transcripts of the key stakeholder interviews. Table 4 describes the key stakeholder organizations contributing to the primary data collection process.

Table 4: Euclid Hospital Key Stakeholder Organizations

Key Stakeholder and Community Organizations	
• City of Cleveland Department of Public Health • Cuyahoga County Board of Health • Euclid Community Advisory Council	• Neighborhood Family Practice • Birthing Beautiful Communities • Lead Safe Cleveland Coalition • Better Health Partnerships • NAMI Greater Cleveland • Asian Services in Action (ASIA) • 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 41 shows key findings from community stakeholder interviews specific to the Euclid Hospital Community.

Figure 41: 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 Euclid Hospital Community from the 2019 CHNA 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

Euclid Hospital'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 narrative 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, participation 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 safety forces, collected unused medications during "National Prescription Take-Back Day" at the hospital.

d. Cleveland Clinic developed suicide and self-harm policies procedures and screening tools for patients in a variety of care settings.

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.

   - 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. Provided free mammograms and skin cancer screenings in partnership with the Willoughby Hills and Stephanie Tubbs Jones Family Health Centers.
    - In partnership with Taussig Cancer Center, our teams collaborated to engage women who lacked access and experienced barriers to complete a mammogram. Patient Navigation team members engaged women prior to their appointment to coordinate transportation and assist with financial payment for clinical services provided. Women who needed additional screening were followed up with and connected to ensure that they were provided the resources and support needed for additional care.
    - In partnership with Medworks, and Taussig Cancer Center, our teams offered a free clinic to patients for general and women's health, including cancer screenings.

c. In partnership with the Euclid Public Library, provided a quarterly health education program.
    - Euclid Hospital partnered with the Euclid Public Library on initiatives that addressed the most prevalent chronic conditions in those communities that surround Euclid Hospital and hiring initiatives.

d. Through the Healthy Communities Initiative (HCI), partner 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. In partnership with the American Lung Association, provided tobacco cessation classes quarterly.
    - Euclid partnered with Community Relations and the Pulmonary team to develop a support group to address tobacco use. This was a free 8-session, 7-week class to provide individuals with the tools to cope with social, mental, emotional, and physical challenges of abstaining from tobacco use.

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.

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.

d. Outreach events like Community Baby Showers provided health information to families in specific high-risk geographical areas and encourage enrollment in supportive evidence-based programs. Community health education continued through virtual education and Centering programs.

Socioeconomic Concerns

Actions and Highlighted Impacts:

a. 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 pilot 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. 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.

f. Provided workforce development and training opportunities for youth K-12 in clinical and non-clinical areas, empowering Northeast Ohio's next generation of leaders.

- 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:
  - Euclid Hospital continues to engage local city school districts such as the City of Euclid's High School, Villa Angela Saint Joseph and Collinwood High School in the Greater Collinwood area in gauging interest in the Pharmacy Tech program where students are trained, can become a paid intern, and can be hired upon completion of the program. Euclid also provided hiring initiatives and workshops to skill up and prepare potential talent for employment at the Cleveland Clinic at the local Euclid Library.
  - Connected Career Rounds provided 4,233 middle and high school students from 76 schools across 7 states including Ohio engaged career conversations with Clinic caregivers.
  - Louis Stokes Summer Internships provided high school interns a paid experience with exposure to clinical and non-clinical healthcare roles.
  - 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.
  - Newbridge Summer Healthcare Careers Institute students who are interested in healthcare careers spend 6-weeks exploring healthcare career opportunities through a variety of in-person experiences at Euclid Hospital
- 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.

g. 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 3) UberHealth for patients within 25 miles of Euclid Hospital who were ambulatory.

h. Food insecurities pilot at Euclid Hospital helped discretely identify patients who need assistance with food or access to food. Through a partnership with UniteUs, a referral is placed for patients who have food security needs where follow up services are offered to patients

i. Euclid Hospital created a self-supported Food Pantry in collaboration with the local food bank and donations from caregivers. This food pantry is available to both inpatients and ED patients of Euclid Hospital.

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, connected 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 podiatrists, nurses, and allied health professionals through partnerships with area nursing colleges and St. Vincent Hospital.

- 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.

Community Feedback

Community Health Needs Assessment reports from 2019 were published on the Euclid Hospital website. 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

Table 5: Euclid Hospital Community Definition

Zip code	Postal Name
44060	Mentor
44092	Wickliffe
44094	Willoughby
44095	Eastlake
44108	Cleveland
44110	Cleveland
44117	Euclid
44119	Cleveland
44123	Euclid
44132	Euclid
44143	Cleveland

Table 6: Population Estimates for Each Zip Code

Zip code	City	Population
44060	Mentor	59,531
44092	Wickliffe	16,457
44094	Willoughby	36,802
44095	Eastlake	32,044
44108	Cleveland	22,563
44110	Cleveland	18,325
44117	Euclid	9,846
44119	Cleveland	11,660
44123	Euclid	16,557
44132	Euclid	14,033
44143	Cleveland	23,896

Table 7: Percentage of Families Living Below Poverty Level for Each Zip Code

Zip Code	City	Families Below Poverty Level (%)
44060	Mentor	3.8%
44092	Wickliffe	3.8%
44094	Willoughby	4.3%
44095	Eastlake	6.2%
44108	Cleveland	24.2%
44110	Cleveland	30.8%
44117	Euclid	10.6%
44119	Cleveland	16.5%
44123	Euclid	15.9%
44132	Euclid	16.1%
44143	Cleveland	4.6%

Table 8: Secondary Data Results by Health Topic—Cuyahoga and Lake Counties

HEALTH TOPICS	CUYAHOGA	LAKE	AVG
Alcohol & Drug Use	1.73	1.81	1.77
Cancer	1.71	1.55	1.63
Children's Health	1.72	1.21	1.47
Diabetes	1.17	1.04	1.10
Health Care Access & Quality	1.21	1.57	1.39
Heart Disease & Stroke	1.35	1.49	1.42
Immunizations & Infectious Diseases	1.20	1.02	1.11
Maternal, Fetal & Infant Health	1.56	1.06	1.31
Medications & Prescriptions	1.72	2.50	2.11
Mental Health & Mental Disorders	1.39	1.16	1.27
Nutrition & Healthy Eating	1.31	1.47	1.39
Older Adults	1.65	1.58	1.61

Oral Health	1.14	1.15	1.14
Other Conditions	1.83	1.69	1.76
Physical Activity	1.39	1.47	1.43
Prevention & Safety	2.21	1.92	2.06
Respiratory Diseases	1.23	1.13	1.18
Tobacco Use	1.19	1.06	1.13
Wellness & Lifestyle	1.49	1.17	1.33
Women's Health	1.46	1.62	1.54
QUALITY OF LIFE TOPIC	**CUYAHOGA**	**LAKE**	**AVG**
Community	1.66	1.14	1.40
Economy	1.68	0.82	1.25
Education	1.55	1.55	1.55
Environmental Health	1.53	1.31	1.42

Secondary Data Scoring Indicators of Concern

Based on the secondary data scoring results, Health Care Access & Quality ranked as the 11th highest scoring health need, 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 9 below. 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 42) 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 8).

Figure 42: 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 9. Data Scoring Results for Healthcare Access & Quality for the Euclid Hospital 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.

Lake County

SCORE	HEALTH CARE ACCESS & QUALITY	Lake County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend

2.50	Consumer Expenditures: Health Insurance	4910.2		4371.7	4321.1			...
2.50	Consumer Expenditures: Medical Services	1242.3		1098.6	1047.4			...
2.50	Consumer Expenditures: Medical Supplies	229.2		204.8	194.9			...
2.50	Consumer Expenditures: Prescription and Non-Prescription Drugs	716.9		638.9	609.6			...
2.33	Primary Care Provider Rate	43		76.7				
1.67	Persons without Health Insurance	5.9		6.6		...	...	

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 10: Secondary Data Scoring Indicators of Concern: Prioritized Health Topic #2: Behavioral Health

Based on the secondary data scoring results, Mental Health & Mental Disorders had the 15th highest data score of all topic areas, with a score of 1.27. 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 10 below.

SCORE	MENTAL HEALTH & MENTAL DISORDERS	Cuyahoga County	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			

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Lake County

SCORE	MENTAL HEALTH & MENTAL DISORDERS	Lake County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
1.64	Depression: Medicare Population	19.2		20.4	18.4			

1.56	Age-Adjusted Death Rate due to Suicide	14.4	12.8	15.1	14.1			

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Table 11: Secondary Data Scoring Indicators of Concern: Prioritized Health Topic #3: Chronic Disease Prevention & Management

Nutrition & Healthy Eating had the 12th highest data score of all topic areas with a score of 1.39. The Older Adult Health topic area had the sixth highest score at 1.61 and the related Other Conditions health topic ranked fourth with a score of 1.76. 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 11.

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			
2.64	People 65+ Living Alone	34.8		28.8	26.1			
2.58	Breast Cancer Incidence Rate	134.8		129.6	126.8			
2.47	People 65+ Living Below Poverty Level	10.9		8.1	9.3			

2.36	Prostate Cancer Incidence Rate	128		107.2	106.2			
2.31	Cancer: Medicare Population	9		8.4	8.4			
2.31	Age-Adjusted Death Rate due to Falls	11.6		10.5	9.5			
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			
2.17	Alzheimer's Disease or Dementia: Medicare Population	11.4		10.4	10.8			
2.14	Colorectal Cancer Incidence Rate	44.2		41.3	38			
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	Adults with Kidney Disease	3.6			3.1			---
1.92	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	35.4		36.1	33.5			
1.78	Age-Adjusted Death Rate due to Cancer	171	122.7	169.4	152.4			
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			
1.69	Age-Adjusted Death Rate due to Kidney Disease	15.2		14.5	12.9			

1.67	People 65+ with Low Access to a Grocery Store	3.4						---
1.67	Colon Cancer Screening	63.7	74.4		66.4			---
1.67	Consumer Expenditures: Fruits and Vegetables	838.8		864.6	1002.1			---
1.58	Adults 65+ with Total Tooth Loss	15.5			13.5			---
1.50	Consumer Expenditures: High Sugar Foods	502.1		519	530.2			---

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Lake County

SCORE	CHRONIC DISEASE PREVENTION & MANAGEMENT	Lake County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.92	Age-Adjusted Death Rate due to Falls	17.3		10.5	9.5			
2.92	Osteoporosis: Medicare Population	8.2		6.2	6.6			

2.64	Atrial Fibrillation: Medicare Population	10		9	8.4			
2.64	Cancer: Medicare Population	9.2		8.4	8.4			
2.47	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	37.4		36.1	33.5			
2.31	Hyperlipidemia: Medicare Population	52.4		49.4	47.7			
2.17	Consumer Expenditures: High Sugar Foods	554.5		519	530.2			...
2.00	Consumer Expenditures: Fast Food Restaurants	1589.1		1461	1638.9			...
2.00	People 65+ with Low Access to a Grocery Store	4.9						...
1.83	Consumer Expenditures: High Sugar Beverages	329.7		319.7	357			...
1.81	Ischemic Heart Disease: Medicare Population	28.5		27.5	26.8			

1.75	Adults with Arthritis	30.2			25.1			---
1.69	Stroke: Medicare Population	4		3.8	3.8			
1.64	Depression: Medicare Population	19.2		20.4	18.4			
1.50	Colon Cancer Screening	64.2	74.4		66.4			---
1.50	Consumer Expenditures: Eldercare	22.3		20.5	34.3			---
1.50	COPD: Medicare Population	12.4		13.2	11.5			

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Table 12: Secondary Data Scoring Indicators of Concern: Prioritized Health Topic #4: Maternal and Child Health

Among all health topics, Maternal, Fetal and Infant Health ranked 14th with a score of 1.31. 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 12 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.

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			---

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Table 13: Secondary Data Scoring Indicators of Concern: Prioritized Health Topic #5: Socioeconomic Issues

Prevention & Safety ranked second among all health topics with a score of 2.06. 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. 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
2.64	Death Rate due to Drug Poisoning	42.6		38.1	21			
2.31	Age-Adjusted Death Rate due to Falls	11.6		10.5	9.5			

2.31	Age-Adjusted Death Rate due to Unintentional Poisonings	42		40.2	21.4			
2.22	Age-Adjusted Death Rate due to Unintentional Injuries	69.7	43.2	68.8	48.9			
2.00	Age-Adjusted Death Rate due to Motor Vehicle Collisions	3.6		2.8	2.5	---	---	---

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Lake County

SCORE	PREVENTION & SAFETY	Lake County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.92	Age-Adjusted Death Rate due to Falls	17.3		10.5	9.5			
2.39	Age-Adjusted Death Rate due to Unintentional Injuries	71.4	43.2	68.8	48.9			
2.14	Age-Adjusted Death Rate due to Unintentional Poisonings	40.2		40.2	21.4			
2.14	Death Rate due to Drug Poisoning	36.9		38.1	21			

1.50	Age-Adjusted Death Rate due to Motor Vehicle Collisions	2.6		2.8	2.5	---	---	---

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 Results by Health Topic for The Euclid Hospital Community in Rank Order by Topic Score

HEALTH TOPICS	AVG
Medications & Prescriptions	2.11
Prevention & Safety	2.06
Alcohol & Drug Use	1.77
Other Conditions	1.76
Cancer	1.63
Older Adults	1.61
Women's Health	1.54
Children's Health	1.47
Physical Activity	1.43
Heart Disease & Stroke	1.42
Health Care Access & Quality	1.39
Nutrition & Healthy Eating	1.39
Wellness & Lifestyle	1.33
Maternal, Fetal & Infant Health	1.31
Mental Health & Mental Disorders	1.27
Respiratory Diseases	1.18
Oral Health	1.14
Tobacco Use	1.13
Immunizations & Infectious Diseases	1.11
Diabetes	1.10

QUALITY OF LIFE TOPIC	SCORE
Education	1.55
Environmental Health	1.42
Community	1.40
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 females aged 15-17*	23.9		19.5		*2016*	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

SCORE	ALCOHOL & DRUG USE	UNITS	LAKE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.72	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	50	28.3	32.2	27	*2015-2019*	9
2.33	Consumer Expenditures: Alcoholic Beverages	*average dollar amount per consumer unit*	724.3		651.5	701.9	*2021*	7
2.17	Adults who Drink Excessively	*percent*	20.8		18.5	19	*2018*	9
2.14	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	36.9		38.1	21	*2017-2019*	9
1.75	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate	*Deaths per 100,000 population*	40.8		42	22.8	*2017-2019*	5
1.42	Adults who Binge Drink	*percent*	16.4			16.7	*2019*	4
1.31	Liquor Store Density	*stores/ 100,000 population*	6.5		5.6	10.5	*2019*	22
1.25	Health Behaviors Ranking	*ranking*	12				*2021*	9
1.19	Mothers who Smoked During Pregnancy	*percent*	9.6	4.3	11.5	5.5	*2020*	17
SCORE	**CANCER**	**UNITS**	**LAKE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.64	Cancer: Medicare Population	*percent*	9.2		8.4	8.4	*2018*	6
2.31	Breast Cancer Incidence Rate	*cases/ 100,000 females*	139.4		129.6	126.8	*2014-2018*	12
2.00	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	8.1		7.9	7.7	*2014-2018*	12
1.92	Adults with Cancer	*percent*	8.5			7.1	*2019*	4

1.92	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	12.6		12.2	11.9	*2014-2018*	12
1.83	All Cancer Incidence Rate	*cases/ 100,000 population*	481.2		467.5	448.6	*2014-2018*	12
1.50	Colon Cancer Screening	*percent*	64.2	74.4		66.4	*2018*	4
1.44	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	20.9	15.3	21.6	19.9	*2015-2019*	12
1.44	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	43.9	25.1	45	36.7	*2015-2019*	12
1.44	Mammogram in Past 2 Years: 50-74	*percent*	73.3	77.1		74.8	*2018*	4
1.33	Age-Adjusted Death Rate due to Prostate Cancer	*deaths/ 100,000 males*	17.7	16.9	19.4	18.9	*2015-2019*	12
1.28	Age-Adjusted Death Rate due to Colorectal Cancer	*deaths/ 100,000 population*	14.7	8.9	14.8	13.4	*2015-2019*	12
1.25	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	66.3		67.3	57.3	*2014-2018*	12
1.19	Colorectal Cancer Incidence Rate	*cases/ 100,000 population*	40.6		41.3	38	*2014-2018*	12
1.11	Age-Adjusted Death Rate due to Cancer	*deaths/ 100,000 population*	163.6	122.7	169.4	152.4	*2015-2019*	12
0.89	Cervical Cancer Screening: 21-65	*Percent*	85.4	84.3		84.7	*2018*	4
0.86	Prostate Cancer Incidence Rate	*cases/ 100,000 males*	95.7		107.2	106.2	*2014-2018*	12
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	**COMMUNITY**	**UNITS**	**LAKE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.72	Alcohol-Impaired Driving Deaths	*percent of driving deaths with alcohol involvement*	50	28.3	32.2	27	*2015-2019*	9
2.64	Workers who Walk to Work	*percent*	1.2		2.2	2.7	*2015-2019*	1
2.31	Social Associations	*membership associations/ 10,000 population*	8.7		11	9.3	*2018*	9
2.19	Workers who Drive Alone to Work	*percent*	86.6		82.9	76.3	*2015-2019*	1
1.67	Violent Crime Rate	*crimes/ 100,000 population*	234.5		303.5	394	*2017*	18

1.50	Age-Adjusted Death Rate due to Motor Vehicle Collisions	*deaths/ 100,000 population*	2.6		2.8	2.5	*2015-2019*	5
1.44	Workers Commuting by Public Transportation	*percent*	1	5.3	1.6	5	*2015-2019*	1
1.36	Linguistic Isolation	*percent*	1.4		1.4	4.4	*2015-2019*	1
1.36	Solo Drivers with a Long Commute	*percent*	32.3		31.1	37	*2015-2019*	9
1.33	Consumer Expenditures: Local Public Transportation	*average dollar amount per consumer unit*	120.9		121.7	148.8	*2021*	7
1.33	Single-Parent Households	*percent*	24		27.1	25.5	*2015-2019*	1
1.25	Social and Economic Factors Ranking	*ranking*	21				*2021*	9
1.19	People 25+ with a Bachelor's Degree or Higher	*percent*	27.4		28.3	32.1	*2015-2019*	1
1.17	Households with Wireless Phone Service	*percent*	96.7		96.8	97	*2020*	8
1.14	Mean Travel Time to Work	*minutes*	23.5		23.7	26.9	*2015-2019*	1
1.03	Voter Turnout: Presidential Election	*percent*	80.3		74		*2020*	20
1.00	Adults with Internet Access	*percent*	95		94.5	95	*2021*	8
1.00	Households with a Smartphone	*percent*	80.6		80.5	81.9	*2021*	8
1.00	Households with No Car and Low Access to a Grocery Store	*percent*	1.6				*2015*	23
0.97	Youth not in School or Working	*percent*	1.4		1.8	1.9	*2015-2019*	1

0.92	People 65+ Living Alone	*percent*	26.2		28.8	26.1	*2015-2019*	1
0.92	Substantiated Child Abuse Rate	*cases/ 1,000 children*	3.9	8.7	6.8		*2020*	3
0.83	Households with a Computer	*percent*	86.6		85.2	86.3	*2021*	8
0.83	Households with an Internet Subscription	*percent*	86.5		82.4	83	*2015-2019*	1
0.83	Households with One or More Types of Computing Devices	*percent*	90.9		89.1	90.3	*2015-2019*	1
0.83	Persons with an Internet Subscription	*percent*	90.2		86.2	86.2	*2015-2019*	1
0.64	Children Living Below Poverty Level	*percent*	11.6		19.9	18.5	*2015-2019*	1
0.64	Young Children Living Below Poverty Level	*percent*	12.1		23	20.3	*2015-2019*	1
0.42	Per Capita Income	*dollars*	34409		31552	34103	*2015-2019*	1
0.39	People Living Below Poverty Level	*percent*	8.1	8	14	13.4	*2015-2019*	1
0.36	Homeownership	*percent*	69.5		59.4	56.2	*2015-2019*	1
0.25	Households without a Vehicle	*percent*	4.6		7.9	8.6	*2015-2019*	1
0.25	Median Household Income	*dollars*	64466		56602	62843	*2015-2019*	1
SCORE	**DIABETES**	**UNITS**	**LAKE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
1.47	Adults 20+ with Diabetes	*percent*	8.6				*2019*	5
1.14	Diabetes: Medicare Population	*percent*	25.6		27.2	27	*2018*	6

0.50	Age-Adjusted Death Rate due to Diabetes	*deaths/ 100,000 population*	17.3		25.3	21.5	*2017-2019*	5
SCORE	**ECONOMY**	**UNITS**	**LAKE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.00	Consumer Expenditures: Homeowner Expenses	*average dollar amount per consumer unit*	8502.5		7828	8900.1	*2021*	7
1.69	SNAP Certified Stores	*stores/ 1,000 population*	0.7				*2017*	23
1.67	Low-Income and Low Access to a Grocery Store	*percent*	7.6				*2015*	23
1.64	Size of Labor Force	*persons*	119998				*Sep-21*	21
1.50	WIC Certified Stores	*stores/ 1,000 population*	0.1				*2016*	23
1.33	Households that are Asset Limited, Income Constrained, Employed (ALICE)	*percent*	23.6		24.5		*2018*	25
1.28	Mortgaged Owners Spending 30% or More of Household Income on Housing	*percent*	22.9		19.7	26.5	*2019*	1
1.25	Social and Economic Factors Ranking	*ranking*	21				*2021*	9
1.17	Students Eligible for the Free Lunch Program	*percent*	20.4				*2019-2020*	13
1.14	Overcrowded Households	*percent of households*	1		1.4		*2015-2019*	1

1.00	Households that are Above the Asset Limited, Income Constrained, Employed (ALICE) Threshold	*percent*	69.2		61.6		*2018*	25
1.00	Households that are Below the Federal Poverty Level	*percent*	7.2		13.8		*2018*	25
0.97	Youth not in School or Working	*percent*	1.4		1.8	1.9	*2015-2019*	1
0.92	Projected Food Insecurity Rate	*percent*	11.8		14.1		*2021*	10
0.83	Adults who Feel Overwhelmed by Financial Burdens	*percent*	13.9		14.6	14.4	*2021*	8
0.83	Food Insecurity Rate	*percent*	10.8		13.2	10.9	*2019*	10
0.83	Households with a Savings Account	*percent*	71.3		68.8	70.2	*2021*	8
0.75	Projected Child Food Insecurity Rate	*percent*	14.8		18.5		*2021*	10
0.69	Renters Spending 30% or More of Household Income on Rent	*percent*	40.4		44.9	49.6	*2015-2019*	1
0.67	Child Food Insecurity Rate	*percent*	13.4		17.4	14.6	*2019*	10
0.67	Income Inequality		0.4		0.5	0.5	*2015-2019*	1
0.64	Children Living Below Poverty Level	*percent*	11.6		19.9	18.5	*2015-2019*	1
0.64	Young Children Living Below Poverty Level	*percent*	12.1		23	20.3	*2015-2019*	1
0.50	Consumer Expenditures: Home Rental Expenses	*average dollar amount per consumer unit*	3322.9		3798.7	5460.2	*2021*	7

0.42	Per Capita Income	*dollars*	34409		31552	34103	*2015-2019*	1
0.42	Severe Housing Problems	*percent*	11.2		13.7	18	*2013-2017*	9
0.39	People Living Below Poverty Level	*percent*	8.1	8	14	13.4	*2015-2019*	1
0.36	Homeownership	*percent*	69.5		59.4	56.2	*2015-2019*	1
0.36	People 65+ Living Below Poverty Level	*percent*	6.2		8.1	9.3	*2015-2019*	1
0.36	Persons with Disability Living in Poverty (5-year)	*percent*	20.4		29.5	26.1	*2015-2019*	1
0.25	Households with Cash Public Assistance Income	*percent*	1.7		2.9	2.4	*2015-2019*	1
0.25	Median Household Income	*dollars*	64466		56602	62843	*2015-2019*	1
0.25	Unemployed Workers in Civilian Labor Force	*percent*	3.4		4.3	4.6	*Sep-21*	21
0.08	Families Living Below Poverty Level	*percent*	5		9.9	9.5	*2015-2019*	1
0.08	People Living 200% Above Poverty Level	*percent*	77.7		68.8	69.1	*2015-2019*	1
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	**ENVIRONMENTAL 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
2.00	People 65+ with Low Access to a Grocery Store	*percent*	4.9				*2015*	23
1.83	Fast Food Restaurant Density	*restaurants/ 1,000 population*	0.8				*2016*	23
1.75	Annual Ozone Air Quality		F				*2017-2019*	2
1.69	SNAP Certified Stores	*stores/ 1,000 population*	0.7				*2017*	23
1.67	Low-Income and Low Access to a Grocery Store	*percent*	7.6				*2015*	23
1.58	Adults with Current Asthma	*percent*	9.8			8.9	*2019*	4
1.50	WIC Certified Stores	*stores/ 1,000 population*	0.1				*2016*	23

1.36	Grocery Store Density	*stores/ 1,000 population*	0.2				*2016*	23
1.36	Number of Extreme Heat Days	*days*	13				*2019*	14
1.36	Number of Extreme Heat Events	*events*	6				*2019*	14
1.36	Number of Extreme Precipitation Days	*days*	34				*2019*	14
1.36	Recognized Carcinogens Released into Air	*pounds*	34566.1				*2020*	24
1.33	Farmers Market Density	*markets/ 1,000 population*	0				*2018*	23
1.31	Liquor Store Density	*stores/ 100,000 population*	6.5		5.6	10.5	*2019*	22
1.25	Annual Particle Pollution		A				*2017-2019*	2
1.25	Physical Environment Ranking	*ranking*	2				*2021*	9
1.17	Recreation and Fitness Facilities	*facilities/ 1,000 population*	0.1				*2016*	23
1.14	Blood Lead Levels in Children (>=5 micrograms per deciliter)	*percent*	0.8		1.9		*2020*	19
1.14	Food Environment Index	*index*	8		6.8	7.8	*2021*	9
1.14	Overcrowded Households	*percent of households*	1		1.4		*2015-2019*	1
1.03	Blood Lead Levels in Children (>=10 micrograms per deciliter)	*percent*	0.2		0.5		*2020*	19
1.00	Households with No Car and Low Access to a Grocery Store	*percent*	1.6				*2015*	23
0.92	Asthma: Medicare Population	*percent*	4.5		4.8	5	*2018*	6

0.83	Access to Exercise Opportunities	*percent*	90.9		83.9	84	*2020*	9
0.53	Houses Built Prior to 1950	*percent*	15		26.2	17.5	*2015-2019*	1
0.42	Severe Housing Problems	*percent*	11.2		13.7	18	*2013-2017*	9
SCORE	**HEALTH CARE ACCESS & QUALITY**	**UNITS**	**LAKE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.50	Consumer Expenditures: Health Insurance	*average dollar amount per consumer unit*	4910.2		4371.7	4321.1	*2021*	7
2.50	Consumer Expenditures: Medical Services	*average dollar amount per consumer unit*	1242.3		1098.6	1047.4	*2021*	7
2.50	Consumer Expenditures: Medical Supplies	*average dollar amount per consumer unit*	229.2		204.8	194.9	*2021*	7
2.50	Consumer Expenditures: Prescription and Non-Prescription Drugs	*average dollar amount per consumer unit*	716.9		638.9	609.6	*2021*	7
2.33	Primary Care Provider Rate	*providers/ 100,000 population*	43		76.7		*2018*	9
1.67	Persons without Health Insurance	*percent*	5.9		6.6		*2019*	1
1.42	Clinical Care Ranking	*ranking*	25				*2021*	9
1.33	Children with Health Insurance	*percent*	95.7		95.2	94.3	*2019*	1
1.33	Non-Physician Primary Care Provider Rate	*providers/ 100,000 population*	69.1		108.9		*2020*	9
1.25	Adults who have had a Routine Checkup	*percent*	78.3			76.6	*2019*	4

1.17	Mental Health Provider Rate	*providers/ 100,000 population*	216		261.3		*2020*	9
0.92	Dentist Rate	*dentists/ 100,000 population*	68.7		64.2		*2019*	9
0.83	Adults who Visited a Dentist	*percent*	53.9		51.6	52.9	*2021*	8
0.83	Adults with Health Insurance: 18+	*percent*	91.4		90.2	90.6	*2021*	8
0.75	Adults without Health Insurance	*percent*	11.2			13	*2019*	4
SCORE	**HEART DISEASE & STROKE**	**UNITS**	**LAKE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.64	Atrial Fibrillation: Medicare Population	*percent*	10		9	8.4	*2018*	6
2.31	Hyperlipidemia: Medicare Population	*percent*	52.4		49.4	47.7	*2018*	6
1.81	Ischemic Heart Disease: Medicare Population	*percent*	28.5		27.5	26.8	*2018*	6
1.69	Stroke: Medicare Population	*percent*	4		3.8	3.8	*2018*	6
1.58	High Cholesterol Prevalence: Adults 18+	*percent*	33.7			33.6	*2019*	4
1.50	Age-Adjusted Death Rate due to Coronary Heart Disease	*deaths/ 100,000 population*	107.6	71.1	101.4	90.5	*2017-2019*	5
1.42	Adults who Experienced Coronary Heart Disease	*percent*	7.2			6.2	*2019*	4
1.33	High Blood Pressure Prevalence	*percent*	34.1	27.7		32.6	*2019*	4

1.31	Heart Failure: Medicare Population	*percent*	13.8		14.7	14	*2018*	6
1.31	Hypertension: Medicare Population	*percent*	57.9		59.5	57.2	*2018*	6
1.25	Adults who Experienced a Stroke	*percent*	3.6			3.4	*2019*	4
1.25	Adults who Have Taken Medications for High Blood Pressure	*percent*	78.4			76.2	*2019*	4
1.25	Cholesterol Test History	*percent*	86.3			87.6	*2019*	4
0.86	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	*deaths/ 100,000 population*	35.9	33.4	42.5	37.2	*2017-2019*	5
0.86	Age-Adjusted Death Rate due to Heart Attack	*deaths/ 100,000 population 35+ years*	42.4		55.4		*2019*	14
SCORE	**IMMUNIZATIONS & INFECTIOUS DISEASES**	**UNITS**	**LAKE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
1.53	COVID-19 Daily Average Case-Fatality Rate	*deaths per 100 cases*	0.2		0	0.5	*28-Jan-22*	11
1.50	Gonorrhea Incidence Rate	*cases/ 100,000 population*	83.9		224	187.8	*2019*	16
1.25	Tuberculosis Incidence Rate	*cases/ 100,000 population*	0.4	1.4	1.1		*2020*	16
1.22	Chlamydia Incidence Rate	*cases/ 100,000 population*	307.7		561.9	551	*2019*	16
1.14	Overcrowded Households	*percent of households*	1		1.4		*2015-2019*	1
1.06	Salmonella Infection Incidence Rate	*cases/ 100,000 population*	11.3	11.1	12.9		*2018*	16

1.03	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	13		14.4	13.8	*2017-2019*	5
0.83	Adults who Agree Vaccine Benefits Outweigh Possible Risks	*Percent*	50		48.6	49.4	*2021*	8
0.58	Persons Fully Vaccinated Against COVID-19	*percent*	63.8				*28-Jan-22*	5
0.08	COVID-19 Daily Average Incidence Rate	*cases per 100,000 population*	30.1		128.4	177.3	*28-Jan-22*	11
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

SCORE	**MEDICATIONS & PRESCRIPTIONS**	**UNITS**	**LAKE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.50	Consumer Expenditures: Medical Services	*average dollar amount per consumer unit*	1242.3		1098.6	1047.4	*2021*	7
2.50	Consumer Expenditures: Medical Supplies	*average dollar amount per consumer unit*	229.2		204.8	194.9	*2021*	7
2.50	Consumer Expenditures: Prescription and Non-Prescription Drugs	*average dollar amount per consumer unit*	716.9		638.9	609.6	*2021*	7
SCORE	**MENTAL HEALTH & MENTAL DISORDERS**	**UNITS**	**LAKE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
1.64	Depression: Medicare Population	*percent*	19.2		20.4	18.4	*2018*	6
1.56	Age-Adjusted Death Rate due to Suicide	*deaths/ 100,000 population*	14.4	12.8	15.1	14.1	*2017-2019*	5
1.42	Poor Mental Health: 14+ Days	*percent*	15			13.6	*2019*	4
1.25	Adults Ever Diagnosed with Depression	*percent*	20.6			18.8	*2019*	4
1.17	Mental Health Provider Rate	*providers/ 100,000 population*	216		261.3		*2020*	9
1.17	Poor Mental Health: Average Number of Days	*days*	4.5		4.8	4.1	*2018*	9
1.03	Alzheimer's Disease or Dementia: Medicare Population	*percent*	9.9		10.4	10.8	*2018*	6

0.83	Self-Reported General Health Assessment: Good or Better	*percent*	86.8		85.6	86.5	*2021*	8
0.36	Age-Adjusted Death Rate due to Alzheimer's Disease	*deaths/ 100,000 population*	25.9		34	30.5	*2017-2019*	5
SCORE	**NUTRITION & HEALTHY EATING**	**UNITS**	**LAKE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.17	Consumer Expenditures: High Sugar Foods	*average dollar amount per consumer unit*	554.5		519	530.2	*2021*	7
2.00	Consumer Expenditures: Fast Food Restaurants	*average dollar amount per consumer unit*	1589.1		1461	1638.9	*2021*	7
1.83	Consumer Expenditures: High Sugar Beverages	*average dollar amount per consumer unit*	329.7		319.7	357	*2021*	7
1.00	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	*Percent*	40.6		41.5	41.2	*2021*	8
1.00	Consumer Expenditures: Fruits and Vegetables	*average dollar amount per consumer unit*	919.9		864.6	1002.1	*2021*	7
0.83	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	*percent*	80.2		80.9	80.4	*2021*	8
SCORE	**OLDER ADULTS**	**UNITS**	**LAKE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.92	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	17.3		10.5	9.5	*2017-2019*	5

2.92	Osteoporosis: Medicare Population	*percent*	8.2		6.2	6.6	*2018*	6
2.64	Atrial Fibrillation: Medicare Population	*percent*	10		9	8.4	*2018*	6
2.64	Cancer: Medicare Population	*percent*	9.2		8.4	8.4	*2018*	6
2.47	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	37.4		36.1	33.5	*2018*	6
2.31	Hyperlipidemia: Medicare Population	*percent*	52.4		49.4	47.7	*2018*	6
2.00	People 65+ with Low Access to a Grocery Store	*percent*	4.9				*2015*	23
1.81	Ischemic Heart Disease: Medicare Population	*percent*	28.5		27.5	26.8	*2018*	6
1.75	Adults with Arthritis	*percent*	30.2			25.1	*2019*	4
1.69	Stroke: Medicare Population	*percent*	4		3.8	3.8	*2018*	6
1.64	Depression: Medicare Population	*percent*	19.2		20.4	18.4	*2018*	6
1.50	Colon Cancer Screening	*percent*	64.2	74.4		66.4	*2018*	4
1.50	Consumer Expenditures: Eldercare	*average dollar amount per consumer unit*	22.3		20.5	34.3	*2021*	7
1.50	COPD: Medicare Population	*percent*	12.4		13.2	11.5	*2018*	6
1.42	Chronic Kidney Disease: Medicare Population	*percent*	22.8		25.3	24.5	*2018*	6

1.31	Heart Failure: Medicare Population	*percent*	13.8		14.7	14	*2018*	6
1.31	Hypertension: Medicare Population	*percent*	57.9		59.5	57.2	*2018*	6
1.14	Diabetes: Medicare Population	*percent*	25.6		27.2	27	*2018*	6
1.08	Adults 65+ who Received Recommended Preventive Services: Females	*percent*	32.9			28.4	*2018*	4
1.03	Alzheimer's Disease or Dementia: Medicare Population	*percent*	9.9		10.4	10.8	*2018*	6
0.92	Adults 65+ who Received Recommended Preventive Services: Males	*percent*	34.4			32.4	*2018*	4
0.92	Adults 65+ with Total Tooth Loss	*percent*	13.2			13.5	*2018*	4
0.92	Asthma: Medicare Population	*percent*	4.5		4.8	5	*2018*	6
0.92	People 65+ Living Alone	*percent*	26.2		28.8	26.1	*2015-2019*	1
0.36	Age-Adjusted Death Rate due to Alzheimer's Disease	*deaths/ 100,000 population*	25.9		34	30.5	*2017-2019*	5
0.36	People 65+ Living Below Poverty Level	*percent*	6.2		8.1	9.3	*2015-2019*	1
SCORE	**ORAL HEALTH**	**UNITS**	**LAKE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
1.92	Oral Cavity and Pharynx Cancer Incidence Rate	*cases/ 100,000 population*	12.6		12.2	11.9	*2014-2018*	12

0.92	Adults 65+ with Total Tooth Loss	*percent*	13.2			13.5	*2018*	4
0.92	Dentist Rate	*dentists/ 100,000 population*	68.7		64.2		*2019*	9
0.83	Adults who Visited a Dentist	*percent*	53.9		51.6	52.9	*2021*	8
SCORE	**OTHER CONDITIONS**	**UNITS**	**LAKE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.92	Osteoporosis: Medicare Population	*percent*	8.2		6.2	6.6	*2018*	6
2.47	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	*percent*	37.4		36.1	33.5	*2018*	6
1.75	Adults with Arthritis	*percent*	30.2			25.1	*2019*	4
1.42	Chronic Kidney Disease: Medicare Population	*percent*	22.8		25.3	24.5	*2018*	6
0.92	Adults with Kidney Disease	*Percent of adults*	3.1			3.1	*2019*	4
0.64	Age-Adjusted Death Rate due to Kidney Disease	*deaths/ 100,000 population*	10.2		14.5	12.9	*2017-2019*	5
SCORE	**PHYSICAL ACTIVITY**	**UNITS**	**LAKE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.64	Workers who Walk to Work	*percent*	1.2		2.2	2.7	*2015-2019*	1
2.00	Children with Low Access to a Grocery Store	*percent*	8				*2015*	23
2.00	People 65+ with Low Access to a Grocery Store	*percent*	4.9				*2015*	23

1.83	Fast Food Restaurant Density	*restaurants/ 1,000 population*	0.8				*2016*	23
1.69	SNAP Certified Stores	*stores/ 1,000 population*	0.7				*2017*	23
1.67	Adults 20+ who are Obese	*percent*	30	36			*2019*	5
1.67	Low-Income and Low Access to a Grocery Store	*percent*	7.6				*2015*	23
1.50	WIC Certified Stores	*stores/ 1,000 population*	0.1				*2016*	23
1.36	Grocery Store Density	*stores/ 1,000 population*	0.2				*2016*	23
1.33	Farmers Market Density	*markets/ 1,000 population*	0				*2018*	23
1.25	Health Behaviors Ranking	*ranking*	12				*2021*	9
1.17	Recreation and Fitness Facilities	*facilities/ 1,000 population*	0.1				*2016*	23
1.14	Food Environment Index	*index*	8		6.8	7.8	*2021*	9
1.03	Adults 20+ who are Sedentary	*percent*	20.4				*2019*	5
1.00	Households with No Car and Low Access to a Grocery Store	*percent*	1.6				*2015*	23
0.83	Access to Exercise Opportunities	*percent*	90.9		83.9	84	*2020*	9
0.83	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	*percent*	80.2		80.9	80.4	*2021*	8
SCORE	**PREVENTION & SAFETY**	**UNITS**	**LAKE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.92	Age-Adjusted Death Rate due to Falls	*deaths/ 100,000 population*	17.3		10.5	9.5	*2017-2019*	5

2.39	Age-Adjusted Death Rate due to Unintentional Injuries	*deaths/ 100,000 population*	71.4	43.2	68.8	48.9	*2017-2019*	5
2.14	Age-Adjusted Death Rate due to Unintentional Poisonings	*deaths/ 100,000 population*	40.2		40.2	21.4	*2017-2019*	5
2.14	Death Rate due to Drug Poisoning	*deaths/ 100,000 population*	36.9		38.1	21	*2017-2019*	9
1.50	Age-Adjusted Death Rate due to Motor Vehicle Collisions	*deaths/ 100,000 population*	2.6		2.8	2.5	*2015-2019*	5
0.42	Severe Housing Problems	*percent*	11.2		13.7	18	*2013-2017*	9
SCORE	**RESPIRATORY DISEASES**	**UNITS**	**LAKE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
1.58	Adults with COPD	*Percent of adults*	8.7			6.6	*2019*	4
1.58	Adults with Current Asthma	*percent*	9.8			8.9	*2019*	4
1.53	COVID-19 Daily Average Case-Fatality Rate	*deaths per 100 cases*	0.2		0	0.5	*28-Jan-22*	11
1.50	COPD: Medicare Population	*percent*	12.4		13.2	11.5	*2018*	6
1.44	Age-Adjusted Death Rate due to Lung Cancer	*deaths/ 100,000 population*	43.9	25.1	45	36.7	*2015-2019*	12
1.42	Adults who Smoke	*percent*	21.1	5	21.4	17	*2018*	9
1.33	Consumer Expenditures: Tobacco and Legal Marijuana	*average dollar amount per consumer unit*	462.7		487.9	422.4	*2021*	7
1.25	Lung and Bronchus Cancer Incidence Rate	*cases/ 100,000 population*	66.3		67.3	57.3	*2014-2018*	12

1.25	Tuberculosis Incidence Rate	*cases/ 100,000 population*	0.4	1.4	1.1		*2020*	16
1.03	Age-Adjusted Death Rate due to Influenza and Pneumonia	*deaths/ 100,000 population*	13		14.4	13.8	*2017-2019*	5
0.92	Asthma: Medicare Population	*percent*	4.5		4.8	5	*2018*	6
0.83	Adults Who Used Electronic Cigarettes: Past 30 Days	*percent*	3.9		4.3	4.1	*2021*	8
0.67	Adults Who Used Smokeless Tobacco: Past 30 Days	*percent*	1.9		2.2	2	*2021*	8
0.53	Age-Adjusted Death Rate due to Chronic Lower Respiratory Diseases	*deaths/ 100,000 population*	39.6		47.8	39.6	*2017-2019*	5
0.08	COVID-19 Daily Average Incidence Rate	*cases per 100,000 population*	30.1		128.4	177.3	*28-Jan-22*	11
SCORE	**TOBACCO USE**	**UNITS**	**LAKE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
1.42	Adults who Smoke	*percent*	21.1	5	21.4	17	*2018*	9
1.33	Consumer Expenditures: Tobacco and Legal Marijuana	*average dollar amount per consumer unit*	462.7		487.9	422.4	*2021*	7
0.83	Adults Who Used Electronic Cigarettes: Past 30 Days	*percent*	3.9		4.3	4.1	*2021*	8
0.67	Adults Who Used Smokeless Tobacco: Past 30 Days	*percent*	1.9		2.2	2	*2021*	8

SCORE	**WELLNESS & LIFESTYLE**	**UNITS**	**LAKE COUNTY**	**HP2030**	**Ohio**	**U.S.**	**MEASUREMENT PERIOD**	**Source**
2.00	Consumer Expenditures: Fast Food Restaurants	*average dollar amount per consumer unit*	1589.1		1461	1638.9	*2021*	7
1.42	Insufficient Sleep	*percent*	38.4	31.4	40.6	35	*2018*	9
1.33	High Blood Pressure Prevalence	*percent*	34.1	27.7		32.6	*2019*	4
1.25	Morbidity Ranking		9				*2021*	9
1.25	Poor Physical Health: 14+ Days	*percent*	13.3			12.5	*2019*	4
1.17	Life Expectancy	*years*	78.5		77	79.2	*2017-2019*	9
1.08	Self-Reported General Health Assessment: Poor or Fair	*percent*	18.3			18.6	*2019*	4
1.00	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	*Percent*	40.6		41.5	41.2	*2021*	8
1.00	Poor Physical Health: Average Number of Days	*days*	3.8		4.1	3.7	*2018*	9
0.83	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	*percent*	80.2		80.9	80.4	*2021*	8
0.83	Adults who Agree Vaccine Benefits Outweigh Possible Risks	*Percent*	50		48.6	49.4	*2021*	8
0.83	Self-Reported General Health Assessment: Good or Better	*percent*	86.8		85.6	86.5	*2021*	8

SCORE	WOMEN'S HEALTH	UNITS	LAKE COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	Source
2.31	Breast Cancer Incidence Rate	*cases/ 100,000 females*	139.4		129.6	126.8	*2014-2018*	12
2.00	Cervical Cancer Incidence Rate	*cases/ 100,000 females*	8.1		7.9	7.7	*2014-2018*	12
1.44	Age-Adjusted Death Rate due to Breast Cancer	*deaths/ 100,000 females*	20.9	15.3	21.6	19.9	*2015-2019*	12
1.44	Mammogram in Past 2 Years: 50-74	*percent*	73.3	77.1		74.8	*2018*	4
0.89	Cervical Cancer Screening: 21-65	*Percent*	85.4	84.3		84.7	*2018*	4

Lake County Data Sources

Key	Data 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

Appendix D: Community Input Assessment Tools

Cleveland Clinic Foundation (CCF) identified key community stakeholders to provide vital perspectives and context around important community health issues. CCF and Conduent Healthy Communities Institute (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 Euclid Hospital 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).[30] 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 Euclid Hospital 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[31]
- 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 Euclid Hospital Community:

[30] Ohio Association of Community Health Centers, https://www.ohiochc.org/page/178
[31] Data search August 15, 2022

- Grace Hospital
- MetroHealth Medical Centers (Multiple Locations)
- St. Vincent Charity Medical Center
- University Hospitals (Multiple Locations)[32]

Other Community Resources

A wide range of agencies, coalitions, and organizations that provide health and social services is available in the region served by Euclid Hospital. 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/

[32] Data search August 15, 2022

Appendix F: Acknowledgements

Conduent Healthy Communities Institute (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
Euclid Hospital

Implementation Strategy Report

2022

EUCLID HOSPITAL 2022 IMPLEMENTATION STRATEGY REPORT

2022 Community Health Needs Assessment
Implementation Strategy Report for Years 2023 – 2025

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EUCLID HOSPITAL 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 findings of the Euclid Hospital 2022 Community Health Needs Assessment ("CHNA"). The Implementation Strategy Report (ISR) includes the priority community health needs identified during the 2022 CHNA and hospital-specific strategies to address those needs from 2023 through 2025.

A. Description of Hospital

Located on 17 acres along the Lake Erie shoreline, Euclid Hospital is home to one of the region's leading rehabilitation and orthopedic centers. The 166 staffed bed[33] hospital offers a complete continuum of care: emergency services, sub-acute care, rehabilitation and outpatient care. Founded in 1907 as Glenville Hospital, Euclid Hospital was constructed at its existing location in 1952.

The hospital has a strong history of caring for the community, which is a tradition that continues today. Euclid Hospital has teamed up with The Cleveland Clinic Foundation and other area hospitals to form the Cleveland Clinic Health System for improved quality and lower cost of care to Northeast Ohio residents. Additional information on the hospital and its services is available at: https://my.clevelandclinic.org/locations/euclid-hospital.

The hospital is part 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.

Euclid Hospital's mission is:

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

II. COMMUNITY DEFINITION

For purposes of this report, the Euclid Hospital community definition is an aggregate of 11 zip codes in Cuyahoga and Lake Counties comprising approximately 75% of inpatient, outpatient, and emergency departments visits in 2021 (Figure 1).

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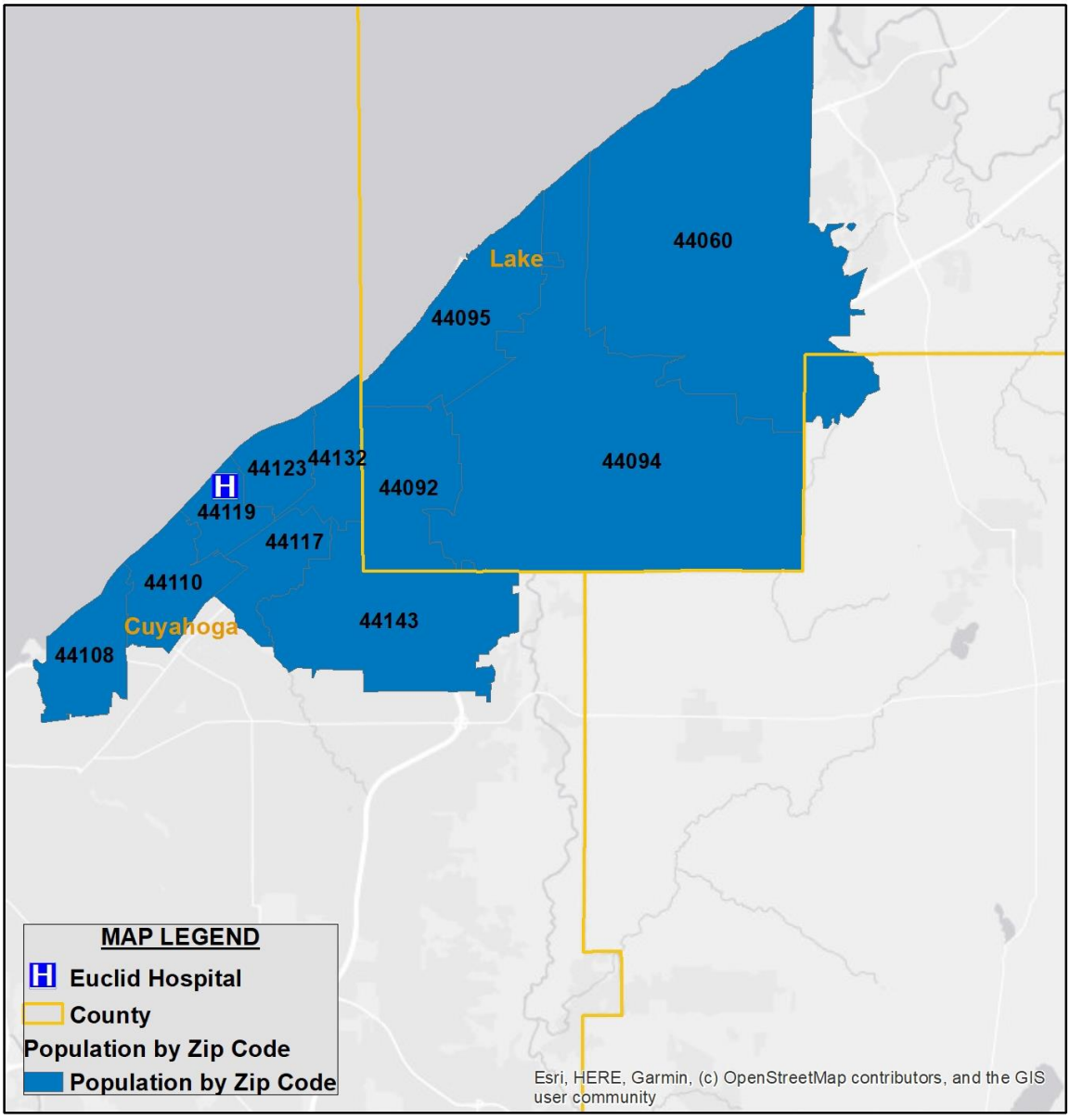
[33] For the purpose of this report and consistent methodology, the Cleveland Clinic MD&A (Q4-2022) interim financial statement is referenced for official bed count. We acknowledge that staffed bed count may fluctuate and may differ from registered or licensed bed counts reflected in other descriptions.

Figure 1: Euclid Hospital Community Definition



III. HOW IMPLEMENTATION STRATEGY WAS DEVELOPED

This Implementation Strategy was developed by members of leadership at Euclid Hospital and Cleveland Clinic representing several departments of the organizations, 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 Euclid Hospital will utilize this Implementation Strategy to determine whether changes should be made to better address the health needs of its communities.

IV. SUMMARY OF THE COMMUNITY HEALTH NEEDS IDENTIFIED

Euclid Hospital'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

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. Cleveland Clinic is committed to promoting health equity and healthy behaviors in our communities. The hospital addresses these overarching themes through a variety of services and initiatives including cross-sector health and economic improvement collaborations, local hiring for the hospital workforce, mentoring of community residents, in-kind donation of time and sponsorships, anchor institution commitment, and caregiver training for inclusion and diversity.

COVID-19 Considerations

The COVID-19 global pandemic declared in early 2020 has caused extraordinary challenges for healthcare systems across the world including Euclid Hospital. 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 Euclid Hospital 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 Expansion of outpatient clinical services offered locally	Improve access for patients who reside within the community Reduce ED utilization and unnecessary hospital admissions

B. Behavioral Health

Euclid Hospital'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 opioid addiction and dependence
B In partnership with safety forces, collect unused medications during "National Prescription Take-Back Day" at the hospital	Reduce the availability of unused prescription opioids within the community
C Provide substance abuse education classes/presentations to local residents and schools	Increase awareness of treatment, reduce stigma, improve early identification of behavioral health conditions

C. Chronic Disease Prevention & Management

Euclid Hospital'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	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 mammograms and skin cancer screenings in partnership with the Willoughby Hills and Stephanie Tubbs Jones Family Health Centers	Increase cancer screening rates

Chronic Disease Prevention & Management (continued)

Initiatives Including Collaborations and Resources Allocated	Anticipated Impacts
C In partnership with the Euclid Public Library, provide a quarterly health education program	Decrease smoking, improve physical activity, improve nutrition, decrease stress levels, improve health literacy, increase the number of individuals who receive regular well-check

D. Maternal & Child Health

Euclid Hospital'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 and Child Health initiatives for 2023-2025 include:

Initiatives Including Collaborations and Resources Allocated	Anticipated Impacts
A Through the Cleveland Clinic enterprise, continue participation 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	Reduce infant mortality inequity, improve the preterm birth rate, decrease sleep-related infant deaths
B Expand capacity to offer the *Centering Pregnancy* group prenatal care model to expecting mothers	Improve the preterm birth rate, increase pregnancy spacing, reduce preterm birth inequity

E. Socioeconomic Issues

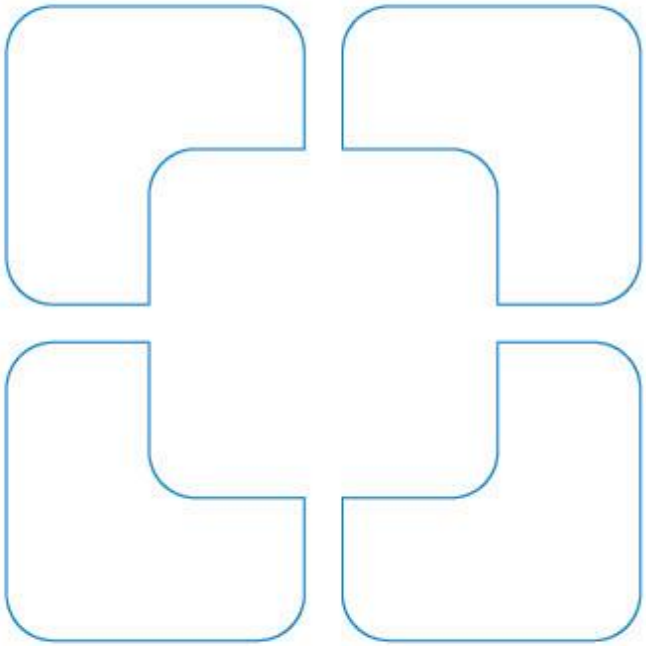
Euclid Hospital's 2022 CHNA demonstrated that health needs are multifaceted, involving medical as well as socioeconomic concerns. The assessment identified food security, affordable housing, employment, transportation, health literacy, structural racism, poverty, and environmental risk factors as significant 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.

The socioeconomic initiatives highlighted 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 Provide workforce development and training opportunities for youth K-12in clinical and non-clinical areas, empowering Northeast Ohio's next generation of leaders	Increase diversity within the healthcare workforce, improve trust in providers, improve local provider shortages

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 Euclid Hospital to improve community health. Through this iterative process, opportunities are identified to grow and expand existing work in prioritized areas as well as implement additional programming in new areas. These ongoing strategic conversations will allow Euclid Hospital to build stronger community collaborations and make smarter, more targeted investments to improve the health of the people in the communities they serve.

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



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