



# 2022 Cuyahoga County Community Health Needs Assessment

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# Acknowledgements

## Cuyahoga County CHNA Steering Committee

Representatives from a number of organizations serving Cuyahoga County formed the Cuyahoga County CHNA Steering Committee to guide Cuyahoga County community partners through the assessment process. Representing a variety of sectors including academia, education, healthcare, as well as social services agencies, these organizations play key roles in optimizing the community's health. The committee met regularly over six months to review secondary data and community feedback, suggest new partners to contribute to the prioritization process, and approve the finalized health needs.

The Cuyahoga County Steering Committee included representation from the following organizations:

- A Vision of Change
- Better Health Partnership
- Case Western Reserve University
- Case Western Reserve University School of Medicine
- Cleveland Clinic
- Cleveland Department of Public Health
- Cuyahoga County Board of Health
- Cuyahoga County Clerk of Courts
- Cuyahoga County Department of Health and Human Services
- The MetroHealth System
- Neighborhood Family Practice
- PolicyBridge
- Southwest General
- St. Vincent Charity Medical Center
- The Center for Health Affairs
- United Way
- University Hospitals

## Local Partners

The Cuyahoga County CHNA Steering Committee gratefully acknowledges the participation of a dedicated group of local partners and external stakeholders that gave generously of their time and expertise to help guide this CHNA report:

- A Vision of Change
- ADAMHS Board of Cuyahoga County
- Alcohol, Drug Addiction and Mental Health Services Board of Cuyahoga County
- Alzheimer's Association
- Asian Services in Action (ASIA)
- Benjamin Rose Institute on Aging
- Better Health Partnership
- Bright Beginnings
- Calvary Hill Church of God in Christ
- Case Western Reserve University
- Case Western Reserve University School of Medicine
- Center for Community Solutions
- Graduate Medical Education - Cleveland Clinic
- Greater Cleveland Food Bank
- Greater Cleveland Transit Authority
- Hand 2 Hand Inc
- Healthy Lucas County
- Helping Hands Development Corporation
- Hispanic Roundtable
- Hospice of the Western Reserve
- LGBT Community Center
- May Dugan
- NAMI Greater Cleveland
- Neighborhood Family Practice
- Neighborhood Leadership Institute

- Center for Health Affairs
- Centers for Families & Children
- City of Cleveland
- City of Cleveland Department of Port Control
- City of Cleveland Division of Emergency Medical Services (EMS)
- Cleveland Black Child Development Institute
- Cleveland Clinic Lakewood Family Health Center
- Cleveland Department of Public Health (CDPH)
- Cleveland Foundation
- Consultamos LLC
- Cuyahoga Community College
- Cuyahoga County
- Cuyahoga County Board of Health
- Cuyahoga County HHS
- Cuyahoga County Office of Homeless Services
- Cuyahoga Metropolitan Housing Authority
- CWRU - Center for Community Health Integration
- Educational Service Center of NEO
- Encore Employment Enterprise
- Esperanza, Inc
- Find the Miracle Within
- Friendly Inn Settlement, Inc.
- Frontline
- Northeast Ohio Neighborhood Health Services (FQHC)
- OhioGuidestone
- PolicyBridge
- Positive Education Program (PEP)
- Positive Women's Network USA Ohio
- Public Health Innovators, LLC & DigitalC
- Select Medical Cleveland Gateway
- Sewa International USA
- Southwest General Health Center
- St Vincent Charity Medical Center
- Step Forward George Forbes Early Learning Center
- Swetland Center for Environmental Health - CWRU
- Taylor Oswald
- The Alzheimer's Association
- The Center for Community Solutions
- The Gathering Place
- The May Dugan Center
- The MetroHealth System
- The MetroHealth System, Institute for H.O.P.E.
- The Nord Family Foundation
- University Hospitals Rainbow Babies & Children's
- UH St John Medical Center
- Unite Us
- United Way of Greater Cleveland
- University Hospitals
- University Hospitals - Pediatric/Women's
- Urban League of Greater Cleveland

## Funders

The Cuyahoga County CHNA Steering Committee gratefully acknowledges the support of a dedicated group of local partners and stakeholders who provided financial support for this 2022 CHNA:

- Cleveland Clinic
- Cleveland Department of Public Health
- Cuyahoga County Board of Health
- HealthComp Foundation
- Southwest General Health Center
- St. Vincent Charity Medical Center
- The MetroHealth System
- University Hospitals

## Consultants

The Cuyahoga County CHNA Steering Committee commissioned Conduent Healthy Communities Institute (HCI) to support report development of Cuyahoga County's 2022 Community Health Needs Assessment. HCI works with clients across the nation to improve community health by assessing needs, developing focused strategies, identifying appropriate intervention programs, establishing monitoring systems, and implementing performance evaluation processes. Report authors from HCI include Ashley Wendt, MPH, Public Health Consultant; Gautami Shikhare, MPH, Research Associate; and Garry Jacinto, Research Coordinator. To learn more about Conduent Healthy Communities Institute, please visit <https://www.conduent.com/community-health/>.

## Suggested Report Citation

2022 Cuyahoga County Community Health Needs Assessment  
Adopted by Southwest General Health Center October 2022  
Adopted by St. Vincent Charity Medical Center on October 5, 2022  
Adopted by University Hospitals on December 14, 2022

## The 2022 Cuyahoga County CHNA is available at:

Cleveland Department of Public Health <https://www.clevelandhealth.org/>

Cuyahoga County Board of Health <https://www.ccbh.net/>

Healthy Northeast Ohio <https://www.healthyneo.org/>

HIP Cuyahoga: <https://hipcuyahoga.org/>

The MetroHealth System: <https://www.metrohealth.org/community/community-health-needs-assessment>

Southwest General: <https://www.swgeneral.com/about-us/community-health-needs-assessment/>

St. Vincent Charity Medical Center: <https://www.stvincentcharity.com/about/community-benefit>

University Hospitals: <http://www.uhhospitals.org/CHNA-IS>

## Written Comments

Individuals are encouraged to submit written comments, questions, or other feedback about the 2022 Cuyahoga County Community Health Needs Assessment to the following individuals:

Cleveland Department of Health [fmills@clevelandohio.gov](mailto:fmills@clevelandohio.gov)

Cuyahoga County Board of Health: [hip.cuyahoga@gmail.com](mailto:hip.cuyahoga@gmail.com)

The MetroHealth System: [InstituteForHOPE@metrohealth.org](mailto:InstituteForHOPE@metrohealth.org)

Southwest General Health System [comalley@swgeneral.com](mailto:comalley@swgeneral.com)

St. Vincent Charity Medical Center: [info@stvincentcharity.com](mailto:info@stvincentcharity.com)

University Hospitals: [communitybenefit@UHHospitals.org](mailto:communitybenefit@UHHospitals.org)

Please note, when submitting your feedback, please make reference to the appropriate section within the report document.

## Community Feedback on 2019 CHNA Report

**Southwest General Health Center** solicited feedback on its 2019 Community Health Needs Assessment, which is posted on its website, but did not receive any comments. Individuals are encouraged to submit written comments on the current joint Community Health Needs Assessment (CHNA) to [comalley@swgeneral.com](mailto:comalley@swgeneral.com). These comments provide additional information to the hospital regarding the broad interests of the community and help to inform future CHNAs and implementation strategies.

**St. Vincent Charity Medical Center** solicited feedback on its 2019 Community Health Needs Assessment and 2020-2022 Implementation Strategy, which are posted on its website, but did not receive any comments. Individuals are encouraged to submit written comments on the current joint Community Health Needs Assessment (CHNA) to Leslie Andrews at [Leslie.Andrews@stvincentcharity.com](mailto:Leslie.Andrews@stvincentcharity.com).

**University Hospitals** solicited feedback on its 2019 Cuyahoga County Community Health Needs Assessment (CHNA), which is posted on its website, but did not receive any comments. Individuals are encouraged to submit written comments on the current joint Community Health Needs Assessment (CHNA) to [CommunityBenefit@UHhospitals.org](mailto:CommunityBenefit@UHhospitals.org). These comments provide additional information to hospital facilities regarding the broad interests of the community and help to inform future CHNAs and implementation strategies.

# Executive Summary

This executive summary provides an overview of health-related data for Cuyahoga County adults (ages 18 and older) from the 2022 Community Health Needs Assessment (CHNA) that was implemented from March to August 2022.

In 2022, Cleveland Clinic, Cleveland Department of Public Health, Cuyahoga County Board of Health, The MetroHealth System, Southwest General Health System, St. Vincent Charity Medical Center, and University Hospitals conducted a joint community health needs assessment (“2022 Cuyahoga County CHNA”). The 2022 Cuyahoga County CHNA is compliant with the requirements set forth by Treas. Reg. §1.501(r) (“Section 501(r)”) and Ohio Revised Code (“ORC”) §3701.981 and serves as the 2022 Community Health Needs Assessment (“CHNA”) for the following hospitals:

- Beachwood RH, LLC (“UH Rehabilitation Hospital”)
- Southwest General Health Center
- St. Vincent Charity Medical Center
- The Parma Community General Hospital Association d/b/a University Hospitals Parma Medical Center
- University Hospitals Ahuja Medical Center
- University Hospitals Cleveland Medical Center
- University Hospitals Rainbow Babies & Children’s Hospital
- University Hospitals St. John Medical Center

*Note: The MetroHealth System is not required to conduct a CHNA for federal compliance purposes but chose to be part of this collaborative CHNA given their strong commitment to community health improvement and addressing social determinants of health.*

The 2022 Cuyahoga County CHNA will serve as a foundation for developing an implementation strategy to address the needs that (a) the partner hospitals determine they are able to meet in whole or in part; (b) are otherwise part of their mission; and (c) are not met (or are not adequately met) by other programs and services in the hospitals' service area.

Similar to the CHNAs that hospitals conduct, completing a Community Health Assessment (CHA) and a corresponding Community Health Improvement Plan (CHIP) are an integral part of the process that local and state health departments must undertake to obtain accreditation through the Public Health Accreditation Board (PHAB). This assessment meets the requirements for PHAB accreditation.

## State of Ohio Requirements

In 2016 the state of Ohio through ORC §3701.981, mandated that all tax-exempt hospitals collaborate with their local health departments on community health assessments (CHA) and community health improvement plans (CHIP). This was done to reduce duplication of resources and provide a more comprehensive approach to addressing health improvement. In addition, local hospitals are required to align with Ohio’s State Health Assessment (SHA) and State Health Improvement Plan (SHIP). The required alignment of the CHNA/CHA process timeline and indicators became effective January 1, 2020.

Conduent HCI worked with the Cuyahoga County CHNA Steering Committee to create a joint county-level CHNA/CHA report that serves both the needs of nonprofit hospital and health department partners, as well as the entire Cuyahoga County community. This was done to exhibit a shared definition of community, data

collection and analysis, and identification of priority needs. It aligns with the 2019 State Health Assessment (SHA), which is the most currently available assessment. This shift in the way health assessments are conducted is a deliberate attempt by the partners to work together more effectively and efficiently to comprehensively address the needs of the community. This 2022 CHNA also reflects the partners' desire to align health assessment planning both among partners at the local level and with state population health planning efforts – as described more fully in *Improving Population Health Planning in Ohio: Guidance for Aligning State and Local Efforts*, released by the Ohio Department of Health (ODH).

## 2019 Ohio State Health Assessment (SHA)

The 2019 Ohio state health assessment (SHA) provides data needed to inform health improvement priorities and strategies in the state. This assessment includes over 140 metrics, organized into data profiles, as well as information gathered through five regional forums, a review of local health department and hospital assessments and plans, and key informant interviews.

Similar to the 2019 Ohio SHA, the 2022 Cuyahoga County Community Health Needs Assessment (CHNA) examined a variety of metrics from various areas of health including, but not limited to, health behaviors, chronic disease, access to healthcare, and social determinants of health. Additionally, the CHNA studied themes and perceptions from local stakeholders from a wide variety of sectors, as well as from community members.

The Ohio SHA identified three priority factors and three priority health outcomes that affect the overall health and well-being of children, families, and adults of all ages in Ohio<sup>1</sup>. These priority topics identified during the proceeding SHA/SHIP remain relevant.

The top health priorities identified during the 2019 Ohio SHA were:

- Mental Health & Addiction
- Chronic Disease
- Maternal and Infant Health

The top priority factors influencing health outcomes identified during the 2019 Ohio SHA were:

- Community Conditions
- Health Behaviors
- Access to Care

The interconnectedness of Ohio's greatest health challenges, along with the overall consistency of health priorities identified in this assessment, indicates many opportunities for collaboration between a wide variety of partners at the state and local level, including physical and behavioral health organizations and sectors beyond health. It is our hope that this CHNA will serve as a foundation for such collaboration.

To view the full 2019 Ohio State Health Assessment, please visit:

<https://odh.ohio.gov/wps/portal/gov/odh/about-us/State-Health-Assessment/State-Health-Assessment>

## Hospital Internal Revenue Services (IRS) Requirements

Certain hospitals as set forth in the Section 501(r) regulations are required to complete a CHNA and corresponding implementation strategy at least once every three years in accordance with regulations

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<sup>1</sup> Health Policy Institute of Ohio, (2022) 2019 SHA and 2020-2022 SHIP. Accessed from <https://www.healthpolicyohio.org/sha-ship/>

promulgated by the Internal Revenue Service pursuant to the Patient Protection and Affordable Care Act (ACA), 2010<sup>2</sup>. Nonprofit hospitals partnering in this CHNA adopted the last joint Cuyahoga County CHNA in October 2019.

## Public Health Accreditation Board (PHAB) Accreditation Requirements

One of the standards to receive and maintain PHAB accreditation, includes participating in or leading a collaborative process that results in a comprehensive community health assessment. For local health departments, the community health assessment assesses the health of residents within the jurisdiction it serves. A local health department’s assessment may also assess the health of residents within a larger region, but the submitted assessment will include details that address the requirements specific to the jurisdiction applying for accreditation<sup>3</sup>.

## Definition of Community & Service Area Determination

The community for this CHNA has been defined as Cuyahoga County. Cuyahoga County is one of Ohio’s largest counties in terms of population. It sits within Northeast Ohio with a northern border of Lake Erie. It includes the City of Cleveland and 58 suburban communities. Two local public health departments are located within the county. Fourteen Cuyahoga County hospital facilities that are part of the 2022 Assessment are located throughout the county and define Cuyahoga County to be their community for the purpose of IRS compliance.

## Inclusion of Vulnerable Populations

The Cuyahoga County CHNA Steering Committee intentionally selected a diverse representation of community voices to provide feedback through key informant interviews and community focus groups. Community stakeholders that participated as key informants represented various community organizations providing services across the county. The broader community was also invited to participate in either of the two virtual prioritization sessions hosted in early August. More details can be found in the [Community Feedback: Primary Data Collection & Analysis](#) section of this report on page 42.

## Process and Methods to Engage the Community

This CHNA process was commissioned by the Cuyahoga County CHNA Steering Committee. The names of the individual partners are listed in the Acknowledgments section at the beginning of the report. Multiple sectors, including the general public, were asked through email list serves, social media, and public notices to participate in the process of qualitative data collection in which included two virtual public prioritization sessions that were hosted in early August 2022. Once the report is released, the general public will be invited to provide feedback.

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<sup>2</sup> The Patient Protection and Affordable Care Act (Pub. L. 111-148) added section 501(r) to the Internal Revenue Code, which imposes new requirements on nonprofit hospitals in order to qualify for an exemption under Section 501(c)(3) and adds new reporting requirements for such hospitals under Section 6033(b) of the Internal Revenue Code. UH followed the final rule entitled “Additional Requirements for Charitable Hospitals; Community Health Needs Assessments for Charitable Hospitals”; Requirement of a Section 4959 Excise Tax Return and Time for Filing the Return, was published by the IRS on December 31, 2014, and requires compliance after December 29, 2015.

<sup>3</sup> Public Health Accreditation Board (2022). Standards and Measures for Reaccreditation Version 2022. Accessed from <https://phaboard.org/wp-content/uploads/Standard-Measures-Version-2022-Reaccreditation.pdf>

## Quantitative and Qualitative Data Analysis

Data for the 2022 Cuyahoga County CHNA were obtained and analyzed by Conduent HCI. Wherever possible, local findings have been compared to other local, regional, state, and national data. As the Cuyahoga County CHNA Steering Committee moves forward with planning strategies, there is a commitment to serving those in Cuyahoga County who experience health and basic needs inequities.

## Identifying and Prioritizing Needs

To better target the most pressing health needs in the community, the Cuyahoga County CHNA Steering Committee convened groups of community members and leaders to participate in two virtual presentations of data on significant health needs facilitated by Conduent HCI. A total of 118 individuals representing local hospital systems, health departments, educational institutions as well as community-based organizations, nonprofits, and the general community attended the presentations. A central piece of the day's proceedings was a presentation and conversation to center equity in the prioritization process. Documents were shared with participants ahead of the meeting to support this discussion. These handouts can be found in [Appendix C](#) on page 201 of this report.

After the key data findings from the 2022 CHNA were presented, community members were invited to vote to prioritize the identified significant health needs for Cuyahoga County. In a separate process the Cuyahoga County CHNA Steering Committee partner agencies met to conduct their own health needs prioritization. Ultimately, overall voting results were combined to produce the final list of significant health needs in ranked order. The Cuyahoga County CHNA Steering Committee then reviewed and discussed the scoring results of the prioritized significant community needs and identified three priority areas to be considered for subsequent implementation planning. These three priority areas are:

1. Behavioral Health (Mental Health & Drug Use/Misuse)
2. Accessible and Affordable Healthcare
3. Community Conditions (Access to Healthy Food & Community Safety)

In addition to these three prioritized health need categories, two prioritized populations were identified, focusing on Maternal, Fetal, and Infant Health as well as the Older Adult population. Finally, [Eliminating Structural Racism and Enhancing Trust](#) across Sectors, People, and Communities will continue to be two overarching focal areas for work in Cuyahoga County. Specific primary and secondary data for each of these priority areas is provided in the [Prioritized Health Needs](#) section of this report on page 51.

While strategically focused work is initiated in these three priority areas, the Cuyahoga County CHNA Steering Committee will continue working together to revisit data findings and community feedback in an iterative process. Additional opportunities will be identified to grow and expand existing work, as well as implement additional programming in new areas. These on-going strategic conversations will allow the Cuyahoga County CHNA Steering Committee and their community partners to build stronger community collaborations and make smarter, more targeted investments to improve the health of the people in Cuyahoga County. This includes focusing on cross-cutting factors and community conditions within their strategy development process that affect all priority areas, which also all overlap with the Ohio SHIP.

## Potential Resources to Address Needs

Priorities identified through the planning process will result in a comprehensive 2023-2025 Cuyahoga County Community Health Improvement Plan (CHIP). The CHIP will also serve as the 2023-2025 Community Health

Implementation Strategy (IS) for the partner nonprofit hospitals. Potential resources available can be found in the [Community Resources Available to Potentially Address Needs](#) section of this report on page 74.

## Evaluation of Impact

The evaluation of impact is a report on the actions taken and effectiveness of strategies implemented since the last CHNA. It can be found in the [Look Back: Progress Since Previous CHNA](#) section of this report on page 18.

## Data Collection Methods

### Secondary Data Collection

Secondary data used for this assessment were collected and analyzed from the Healthy Northeast Ohio (NEO) community data platform. [Healthy NEO](#) is a publicly available website which houses population health data and resources to support community health improvement efforts across a 9-county region. The data on this platform, maintained by researchers and analysts at Conduent HCI, includes over 200 community indicators, spanning at least 24 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, national targets, and to previous time periods.

### Secondary Data Analysis Results

The following health and quality of life topic areas were identified through the secondary data analysis as being significant health needs in Cuyahoga County:

- Alcohol & Drug Use
- Cancer
- Children’s Health
- Community
- Economy
- Education
- Environmental Health
- Maternal, Fetal, & Infant Health
- Medications & Prescriptions
- Older Adults
- Other Conditions
- Prevention & Safety

### Primary Data Collection

To ensure the perspectives of community members were included, input was collected from residents in Cuyahoga County. Primary data used in this assessment consisted of Key Informant Interviews with key community stakeholders and Focus Group discussions with key community groups.

### Key Informant Interviews

One method of community input was gathering qualitative feedback through Key Informant Interviews. Thirty-two Key Informant Interviews were conducted from May to July 2022.

### Focus Groups

Three separate discussions were conducted by University Hospitals and The Center for Health Affairs in August 2022 to gain deeper understanding of health issues impacting the residents of Cuyahoga County.

### Qualitative Analysis Results

Detailed transcripts from the Key Informant Interviews and Focus Group discussions were captured. The text from these transcripts was analyzed using the qualitative analysis tool Dedoose®. Text was coded using a pre-designed codebook, organized by themes, and analyzed for significant observations. The main themes and topics that emerged from these discussions included:

- Accessible and Affordable Healthcare
- Access to Healthy Food
- Behavioral Health
- Community Safety
- Economy
- Education
- Environmental Health
- Maternal, Fetal, & Infant Health
- Structural and Institutional Racism
- Older Adults

Additional details of these secondary and primary data collection processes can be found later in this report in the [Primary and Secondary Data Methodology and Key Findings](#) section.

# Introduction & Purpose

The Cuyahoga County CHNA Steering Committee, including Center for Health Affairs, Cleveland Clinic, Cleveland Department of Public Health, Cuyahoga County Board of Health, CWRU School of Medicine, The MetroHealth System, Southwest General Health System, St. Vincent Charity Medical Center, and University Hospitals, is pleased to present the 2022 Cuyahoga County Community Health Needs Assessment (CHNA).

## CHNA Purpose

The purpose of this CHNA report is to identify and prioritize significant health needs of the community in Cuyahoga County, Ohio served by the hospitals and health departments that constitute the Cuyahoga County CHNA Steering Committee. The priorities identified in this report help to guide community health improvement programs and community benefit activities, as well as collaborative efforts with other organizations that share a mission to improve health.

Completion of a Community Health Needs Assessment every three years is required for non-profit hospital systems to retain their Internal Revenue Service 501(c)(3) status. Local health departments seeking accreditation from the Public Health Accreditation Board are required to conduct a Community Health Assessment every five years, and the Ohio Department of Health requires a Community Health Assessment every three years. This CHNA report meets requirements for all of the above.

To avoid duplication of assessment efforts and enhance collaboration and coordination between clinical care and public health in Cuyahoga County, Cleveland Clinic, Cleveland Department of Public Health, Cuyahoga County Board of Health, The MetroHealth System, Southwest General Health System, St. Vincent Charity Medical Center, and University Hospitals implemented a collaborative Community Health Needs Assessment.

## Overview

Planned in coordination with county partners and stakeholders, the Cuyahoga County Community Health Needs Assessment (CHNA) was conducted by the Cuyahoga County CHNA Steering Committee and included the collection and analysis of both quantitative and qualitative data. Data collection activities included:

- Secondary Data Analysis of over 200 community indicators, spanning at least 24 topics in the areas of health and quality of life
- Thirty-two Key Informant Interviews with key community partners
- Three community Focus Groups with Cuyahoga County residents

## Summary of Findings

Health needs were determined to be significant if they met the following criteria:

- Secondary data analysis: Health and Quality of Life topics that received a score of 1.50 or higher according to HCI's Secondary Data Scoring Tool were considered a significant health need. Six topics scored at or above the threshold. Topic areas with fewer than three indicators were considered a data gap.

- Qualitative analysis: frequency topic was discussed within/across interviews and the focus groups.

Through this criteria, ten needs emerged as significant. Figure 1 illustrates the final ten significant health needs, listed in alphabetical order, that were included for prioritization, based on the findings of all forms of data collected for the Cuyahoga County 2022 CHNA.

**Figure 1. Cuyahoga County Significant Health Needs**



## 2022 Prioritized Health Needs

The Cuyahoga County CHNA Steering Committee convened a group of stakeholders and community members to participate in two virtual presentations of data on the ten significant health needs. Following the presentation, participants engaged in a discussion and were asked to participate in a prioritization voting activity.

### Process and Criteria

The community prioritization activity included these criteria for prioritization:

- Magnitude of the Problem
- Ability to Impact
- Inequities & Social Determinants of Health

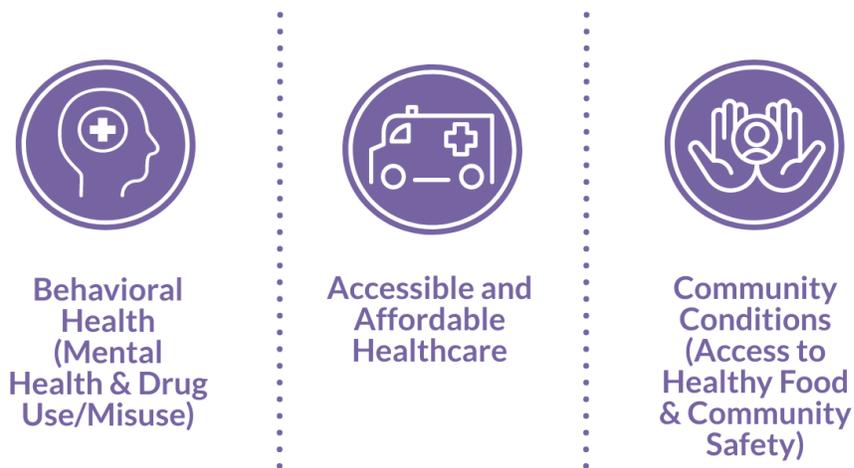
In a separate process following the community-facing prioritizations, the Cuyahoga County CHNA Steering Committee partner agencies met to conduct their own prioritization of the significant health needs.

The partner agency criteria included:

- Magnitude of the Problem
- Severity of the Problem
- Inequities & Social Determinants of Health
- Magnitude of the Health Disparity
- Priorities Determined by Community
- Alignment with SHA/SHIP

Ultimately, the overall voting results were combined to produce a final list of significant health needs in ranked order. The Cuyahoga County CHNA Steering Committee then reviewed and discussed the scoring results of the prioritized community needs and identified three priority areas to be considered for subsequent implementation planning.

**Figure 2. Cuyahoga County Prioritized Health Needs**



## Cuyahoga County CHNA Steering Committee: History of Collaboration

A tremendous wealth of community assets and healthcare resources exist in Cuyahoga County, yet stark inequities in health are experienced by its residents. The conditions that shape health (commonly referred to as the social and environmental determinants of health) – such as financial resources, access to healthy food, and safe and affordable housing, to name a few – are not spread equitably, resulting in differences in health outcomes, such as disease severity, life expectancy and infant mortality. These differences are shaped by long-standing systems and structures that impact the conditions in which residents live, work, learn and play. The decision to work collaboratively highlights that these problems cannot be solved by the isolated actions of individual organizations, but are resolvable through cross-sector, cooperative action. Partners agree that effectively addressing health inequities in Cuyahoga County requires trust, transparency, and employing an equity lens to align local and state community health improvement efforts.

### Moving from Separate Health Assessments toward Greater Collaboration for Collective Impact

Certain hospitals are required to complete a CHNA and corresponding implementation strategy (IS) at least once every three years in accordance with 501(r) Regulations developed by the Internal Revenue Service, as a result of the Patient Protection and Affordable Care Act (ACA), 2010. In looking at the population served by the hospital facilities and Cuyahoga County as a whole, it was clear that all facilities that are a part of this CHNA define their community to be the same. Similar to the CHNAs that hospitals conduct, completing a Community Health Assessment (CHA) and a corresponding Community Health Improvement Plan (CHIP) is an important part of the process that local and state health departments must complete to seek accreditation through the Public Health Accreditation Board (PHAB). The Ohio Department of Health required all local health departments to apply to become accredited through PHAB by 2018 and to be accredited by 2020. The initial 2013 CHA and 2015 CHIP, facilitated by The Health Improvement Partnership-Cuyahoga (HIP-Cuyahoga) partners, were performed independently from local hospital systems' CHNAs and Implementation Strategies.

### Historical Context of Collaborative Assessment Process

During the process of developing the 2013 CHA, an equity-grounded, multi-sector collective impact consortium, known as the Health Improvement Partnership-Cuyahoga (HIP-Cuyahoga), evolved from longstanding working groups to a multi-sector consortium to make it easier to do collaborative community health improvement work across Cuyahoga County. HIP-Cuyahoga's backbone organization is the Cuyahoga County Board of Health and is supported by five other anchor organizations. Over time, the consortium grew to include over 300 community agencies and more than 1,000 individual stakeholders, including members of the public representing various neighborhoods. HIP-Cuyahoga's four key approaches are perspective transformation, collective impact, community engagement, and health and equity in all policies.

One of the four HIP-Cuyahoga subcommittees created based on the 2013 CHA, was focused on improving collaboration between public health and clinical care. Multiple stakeholders created the following objective, which set the foundation for the combined health assessment in this document: to develop an integrated system to conduct future coordinated, comprehensive countywide community, clinical and behavioral health assessments to identify future priority focus area(s) through a clinical care and public health multi-stakeholder partnership. This group of HIP-Cuyahoga members worked for over six years to develop authentic relationships with the area's regional hospital association, The Center for Health Affairs, and individual hospital systems to realize this vision.

## Conducting Joint Assessments in Cuyahoga County

Historically, public health and hospital stakeholders in Cuyahoga County completed independent assessments to understand the health needs of the community, and they developed independent plans for responding to those needs. In 2018, the Cleveland Department of Public Health, the Cuyahoga County Board of Health and University Hospitals, together with Case Western Reserve University School of Medicine, HIP-Cuyahoga, and The Center for Health Affairs, committed their time and resources to bridging public health and clinical care by conducting a health assessment of Cuyahoga County together. The 2018 Cuyahoga County Community Health Assessment was the first joint assessment of its kind in Cuyahoga County and represented a new, more effective and collaborative approach to identifying and addressing the health needs of the community. A corresponding report, the 2019 Cuyahoga County Community Health Implementation Strategy, was developed to address the health needs identified in the 2018 Assessment through building on existing community strengths and resources.

These two reports enabled the Cleveland Department of Public Health, the Cuyahoga County Board of Health and University Hospitals to partner and align their health assessment and planning efforts on a smaller scale, prior to conducting the more comprehensive 2019 Cuyahoga County Community Health Needs Assessment with additional Cuyahoga County hospitals and other stakeholders. The results of the 2019 Cuyahoga County Community Health Needs Assessment informed the development of a robust 2020-2022 Implementation Strategy and Community Health Improvement Plan.

The Cuyahoga County Steering Committee came together once again in 2022 to conduct this most recent collaborative CHNA.



# Look Back-Progress Since Prior CHNA

The previous collaborative Cuyahoga County CHNA was implemented in 2019. An important piece of the current assessment cycle includes the ongoing review of progress made on priority health topics set forth in the preceding CHNA and Community Health Improvement Plan (CHIP) (Figure 3). By reviewing the actions taken to address priority health issues and evaluating the impact those actions have made in the community, it is possible to better target resources during the next assessment.

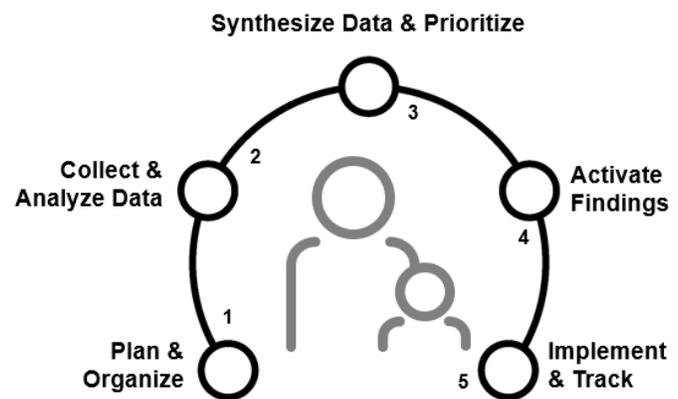
## Priority Health Needs from Preceding CHNA

Cuyahoga County's five priority health areas from the 2019 CHNA were:

- Eliminating structural racism\*
- Enhancing trust and trustworthiness across sectors, people, communities\*
- Addressing community conditions, such as reducing poverty and its effects
- Enhancing mental health and reducing substance abuse
- Reducing chronic illness and its effects

*\* Long-term, cross-cutting strategies that will be integrated into each of the other priority areas through a plan to address these fundamental contributors to the health of individuals and populations within Cuyahoga County.*

Figure 3. The CHNA Cycle



## Evaluation of Impact

### Evaluation of Hospital Community Health Improvement Efforts

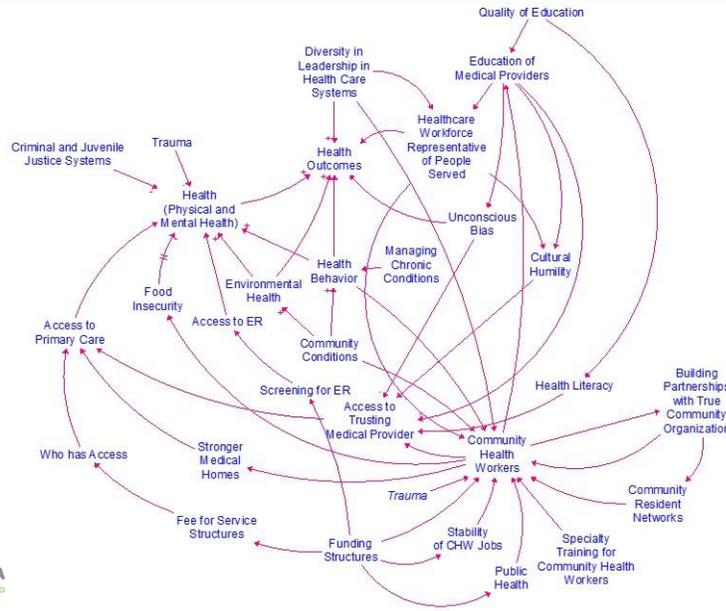
An evaluation of the impact of the strategies Southwest General Health Center, St. Vincent Charity and the seven University Hospitals facilities that are located within Cuyahoga County and are presented in [Appendix A](#) on page 82 of this report.

### Collaborative work to address structural racism in Cuyahoga County using Community-Based System Dynamics

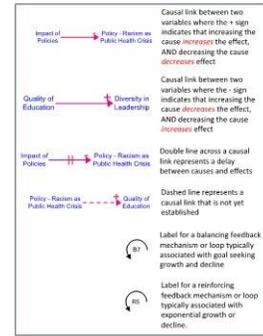
The longstanding HIP-Cuyahoga work toward eliminating structural racism, and the resulting cross-sector infrastructure, has positioned us for continued progress. To move to the next level, a method was needed to allow partners to see complexly the related factors that cause and sustain structural racism, in order to foster



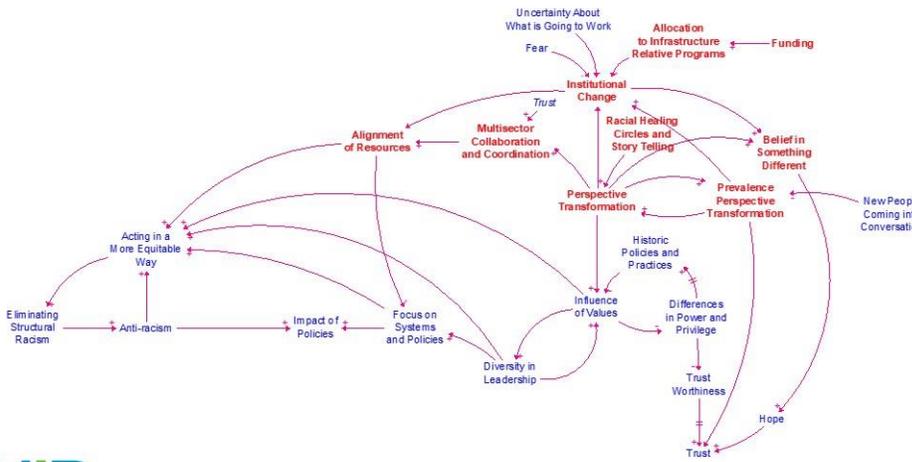
## Health and Healthcare



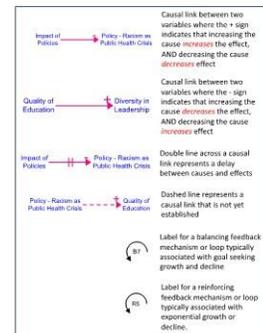
- Central role of community health workers (CHW) as creating connections between providers, communities, and education of medical providers
- Increasing stability of CHW jobs



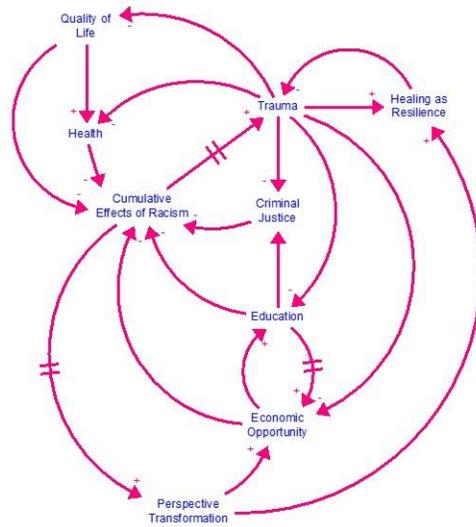
## Perspective Transformation



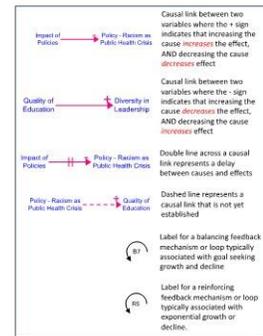
- Few changes to the initial structure on perspective transformation from the CMT
- Racial healing circles and story telling added as an intervention
- Building support for the short and long-term



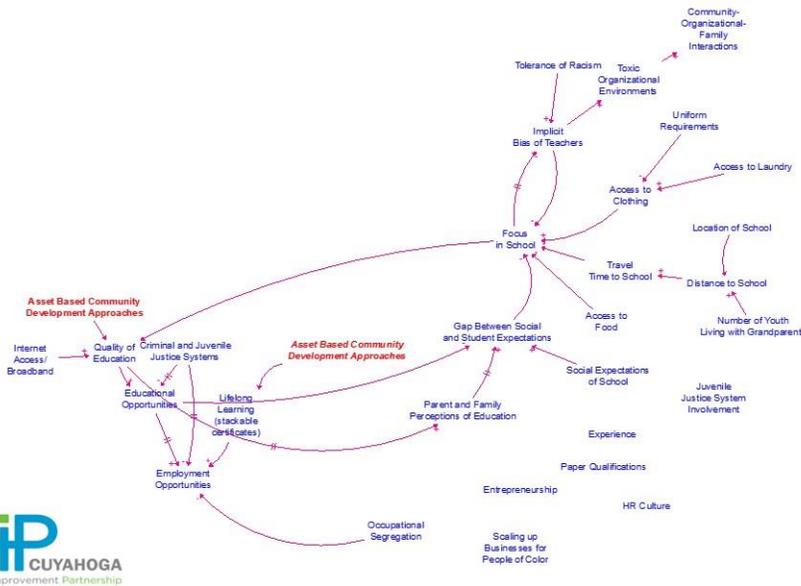
## Racial Trauma and Healing Small Group



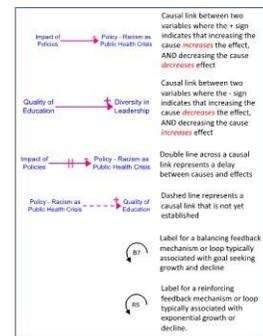
- Draft of simplified high-level overview of system map
- Emphasis on cumulative effects of racism, trauma, and healing as resilience



## Education and Economic Opportunity



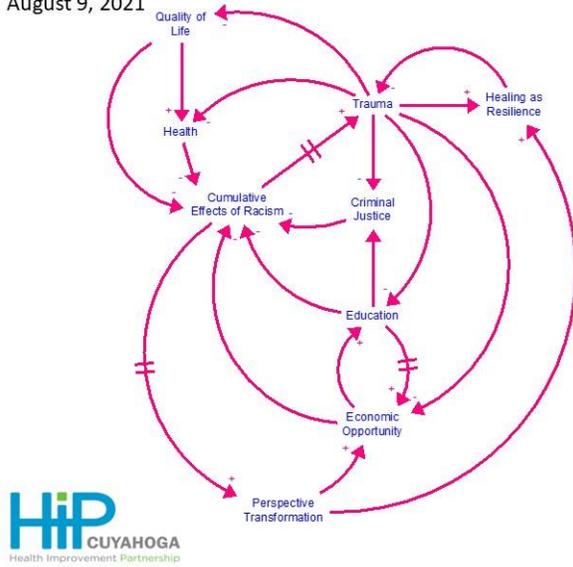
- Many factors related to access to basic social needs so students can focus
- Similar workforce and leadership issues across schools, government, businesses, etc.
- Look at/use existing structures?



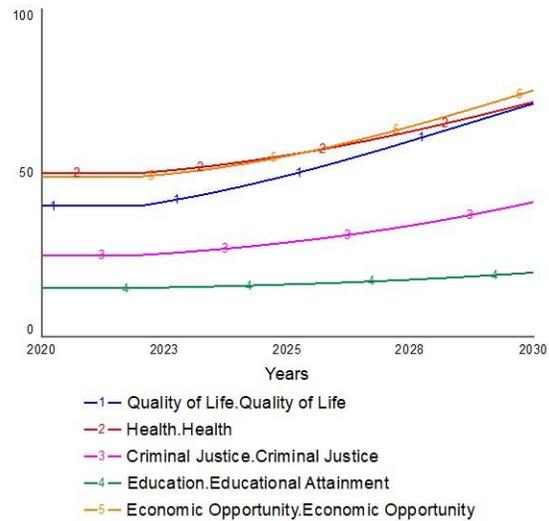
Computer simulation models, created by our partners at the Center for Community Health Integration at Case Western Reserve University, Drs. Peter Hovmand and Robinson Salazar, use the causal loop diagrams developed in this work to identify different leverage points for systemic change and to evaluate the impact of community-proposed solutions. An example of one of these models is shown below. The QR code takes the reader to a website with different simulations to examine the combined effect of changing factors affecting systems change for equity.

**Systems Change for Racial Equity (SCORE) Model**

August 9, 2021



<https://exchange.iseesystems.com/public/psh/score>



As this work was happening, the Cuyahoga County Citizen’s Advisory Council on Equity (CACE)<sup>6</sup> was created to operationalize the County Council declaration of racism as a public health crisis.<sup>7</sup> Dr. Heidi Gullett was nominated by Cuyahoga County Executive Armond Budish to CACE in July 2020, with Dr. Hovmand working closely to support CACE by integrating stakeholder interviews and documents into the system map and begin to capture the CACE proposed interventions to address racism as a public health crisis. Dr. Gullett also serves on the City of Cleveland workgroup focused on operationalizing action after declarations of racism as a public health crisis which also are using the system maps to guide their efforts. CACE and the City of Cleveland workgroup continue to apply these methods to understand the system and to identify solutions within it.

The team developed a [Systems Thinking Toolkit](#) to help community members understand and talk about this work, and also to use it as a tool to support eliminating structural racism.

A [flipbook](#) created by the Robert Wood Johnson Foundation Cross-Sector Innovation Initiative provides a brief overview of this work.

The findings also have been disseminated to a larger audience through publication in the [Journal of Public Health Management and Practice](#).<sup>8</sup>

<sup>6</sup> Citizens' Advisory Council on Equity. <http://executive.cuyahogacounty.us/en-US/Citizens-Advisory-Council-Equity.aspx>

<sup>7</sup> Resolution No. R2020-0122: A resolution declaring racism a public health crisis in Cuyahoga County, and declaring the necessity that this Resolution become immediately effective. (2020).

<sup>8</sup> Gullett HL, Brown GL, Collins D, et al. Using community-based system dynamics to address structural racism in community health improvement. *Journal of Public Health Management and Practice*. 2022;28(4):S130-S137. doi:10.1097/PHH.0000000000001492

# Demographics of Cuyahoga County

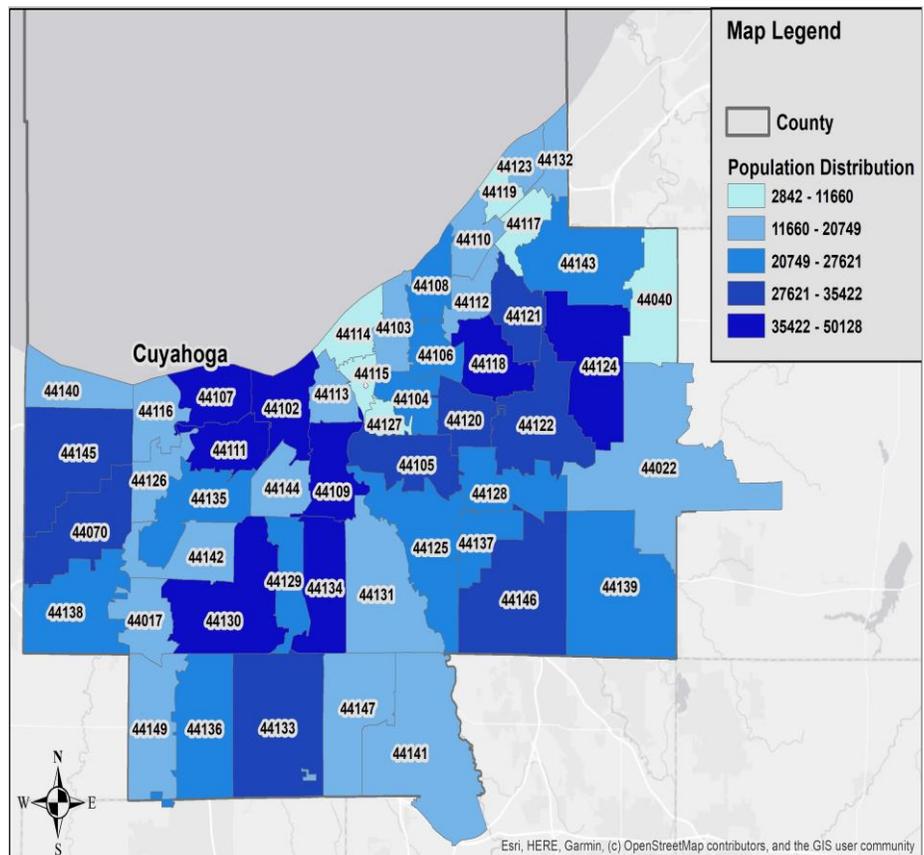
The demographics of a community significantly impact its health profile. Different racial, ethnic, age, and socioeconomic groups may have unique needs and require varied approaches to health improvement efforts. The following section explores the demographic profile of the community residing in Cuyahoga County.

## Geography and Data Sources

Data are presented in this section at the geographic level of Cuyahoga County. Comparisons to county, state, and national values are also provided when available. All demographic estimates are sourced from Claritas Pop-Facts (2022 population estimates)<sup>9</sup> and American Community Survey<sup>10</sup> one-year (2019) or five-year (2016-2020) estimates, unless otherwise indicated. Population

According to 2022 Claritas Pop-Facts population estimates, Cuyahoga County has an estimated population of 1,229,828 persons. Figure 4 shows the population size in each zip code, with the darkest blue representing the zip codes with the largest populations. [Appendix B](#) (beginning on page 153) provides the population estimates for each zip code. The most populated zip code within Cuyahoga County is 44107, with a population of 50,128, followed by 44130, with a population of 48,243.

Figure 4: Cuyahoga County Population by Zip Code



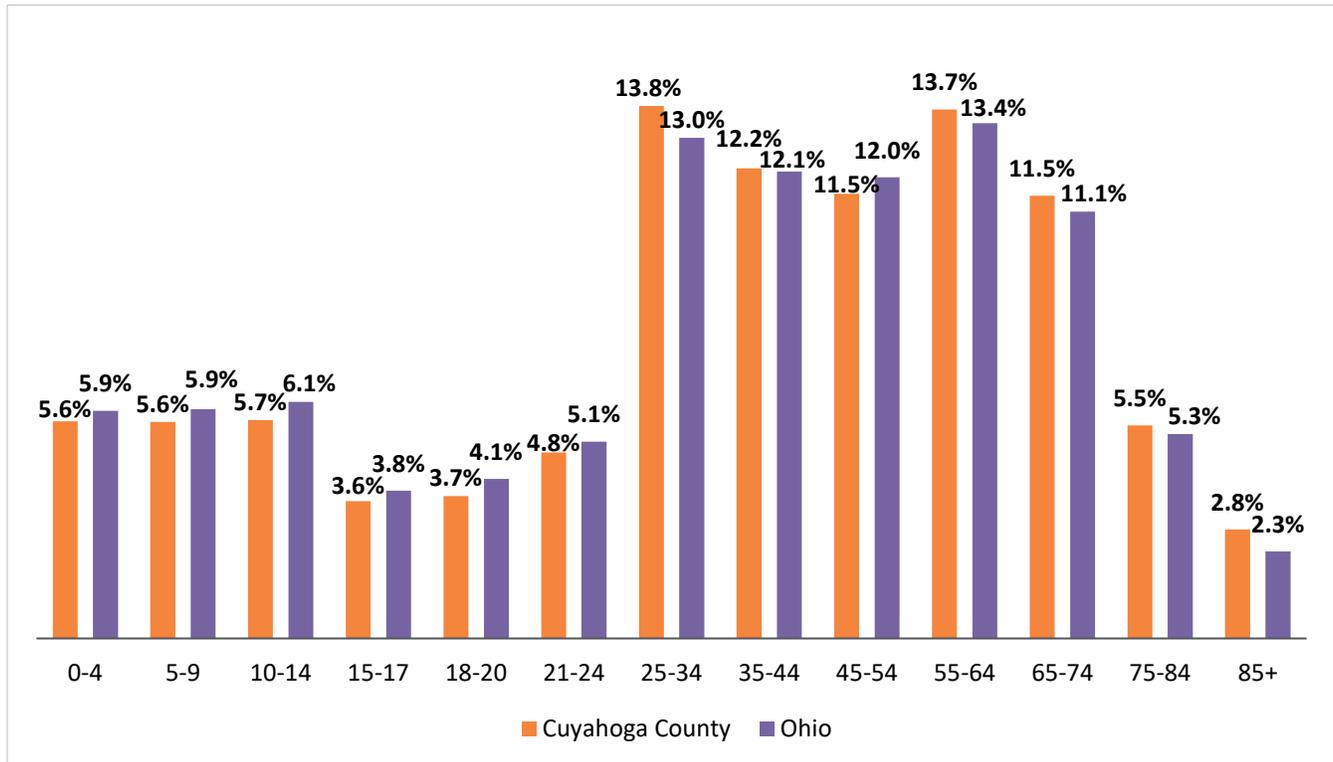
<sup>9</sup> Healthy Northeast Ohio online platform. <https://www.healthyneo.org/>

<sup>10</sup> American Community Survey. <https://www.census.gov/programs-surveys/acs>

## Age

Children (ages 0-17) comprised 20.5% of the population in Cuyahoga County. When compared to Ohio (21.8%) and the U.S (22.4%), Cuyahoga County has a smaller percentage population of children (ages 0-17). In Cuyahoga County, 19.8% of the population is aged 65+, which is a higher proportion in comparison to all of Ohio (18.6%) and the U.S. (16.0%). Figure 5 shows a further breakdown of the population by age.

Figure 5: Population by Age: County and State Comparisons



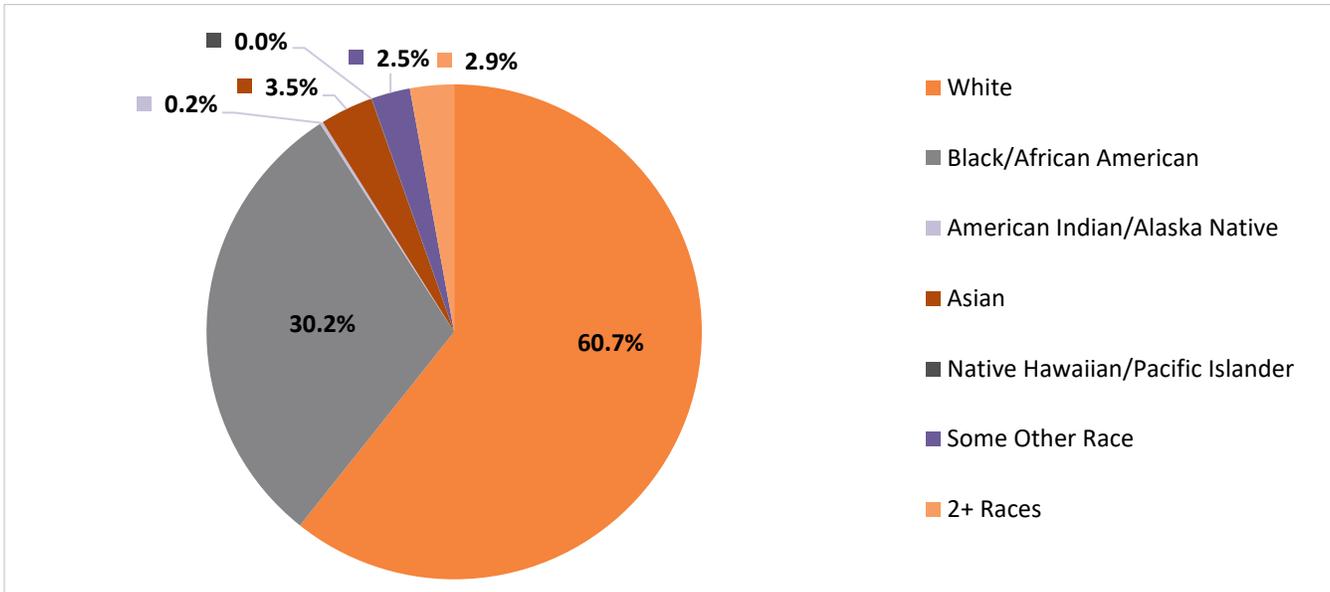
County and state values- Claritas Pop-Facts (2022 population estimates)

## Race and Ethnicity

The racial and ethnic composition of a population is important in planning for future interventions and strategies, particularly for schools, businesses, community centers, healthcare, and childcare. Analysis of health and social determinants of health data by race and ethnicity can also help identify disparities in housing, employment, income, and poverty.

The racial makeup of Cuyahoga County includes 60.7% of the population identifying as White or Caucasian, as indicated in Figure 6. The proportion of the population that identifies as Black/African American is the second largest of all races in Cuyahoga County at 30.2%.

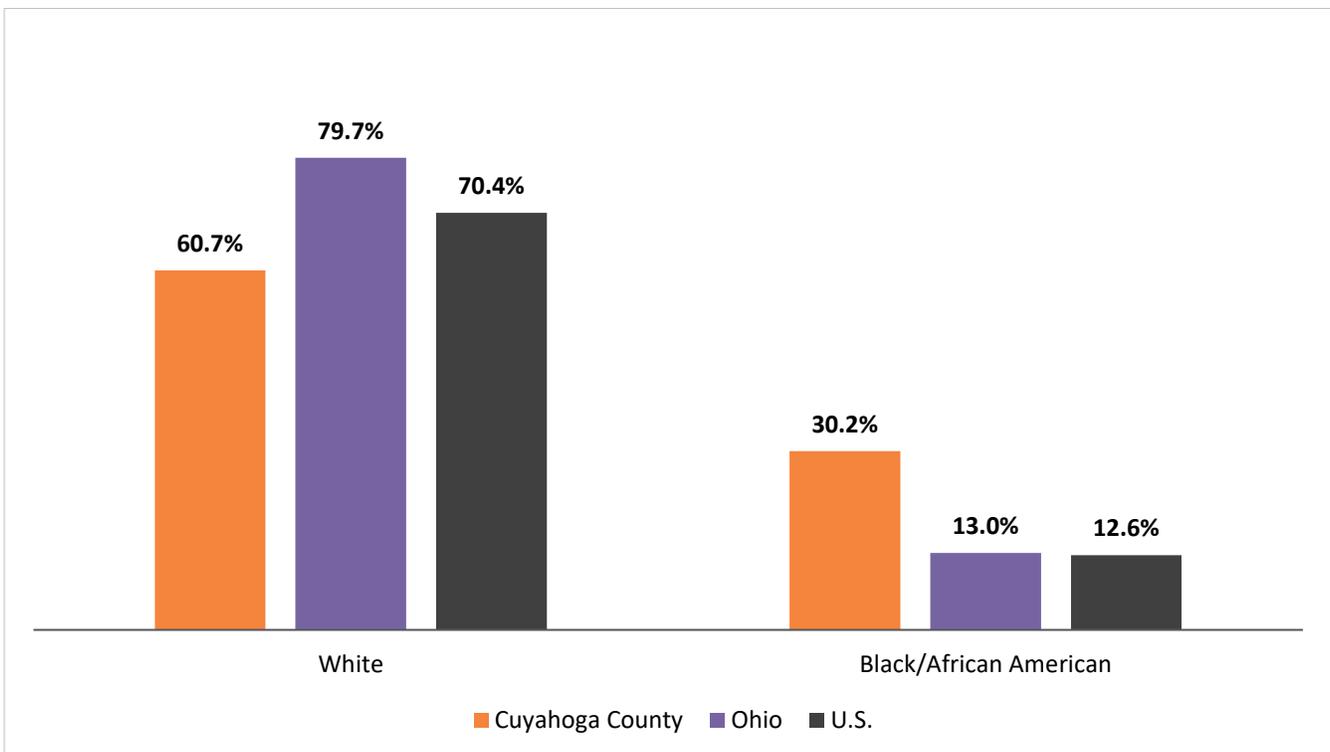
Figure 6: Population by Race: Cuyahoga County



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

Community members identifying as White represent a smaller proportion of the population in Cuyahoga County (60.7%) when compared to Ohio (79.7%) and the U.S. (70.4%), while Black/African American persons represent a higher proportion of the population of the county (30.2%) compared to Ohio (13.0%) and the U.S. (12.6%) (Figure 7).

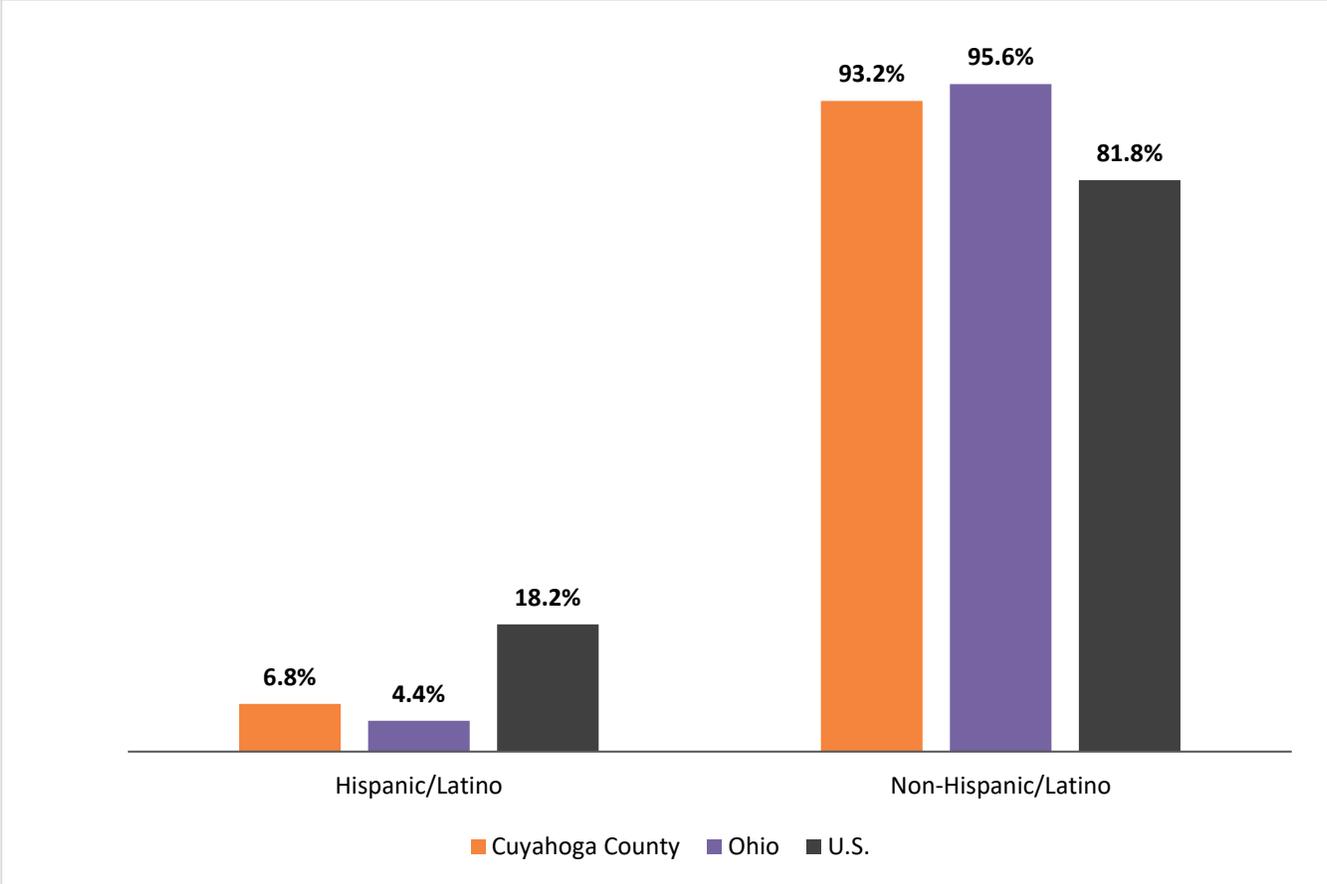
Figure 7: Population by Race: Cuyahoga County, State, and U.S. Comparisons



County and state values- Claritas Pop-Facts (2022 population estimates), U.S. values taken from American Community Survey five-year (2016-2020) estimates

As shown in Figure 8, 6.8% of the population in Cuyahoga County identify as Hispanic/Latino. This is a larger proportion of the population when compared to Ohio (4.4%), but a smaller proportion of the population compared to the U.S. (18.2%).

**Figure 8: Population by Ethnicity: Cuyahoga 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 (2016-2020) estimates

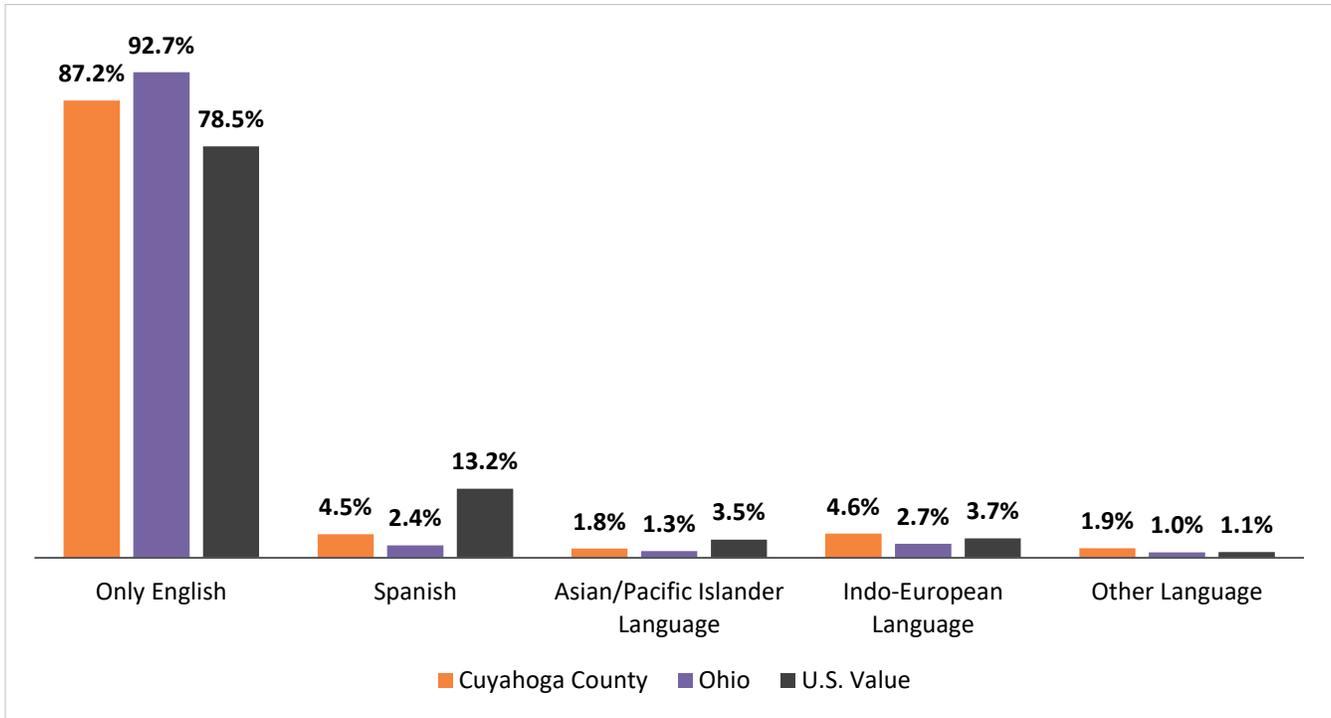
**Language and Immigration**

Understanding the community’s countries of origin and languages spoken at home helps inform the cultural and linguistic context for local health and public health systems. According to the American Community Survey, 7.6% of residents in Cuyahoga County were born outside of the U.S., which is lower than the U.S. value of 13.5%.<sup>11</sup>

In Cuyahoga County, 87.2% of the population of ages five and older speak only English at home, which is lower than the state percentage of 92.7%, but higher than the U.S. percentage of 78.5% (Figure 9). These data also show that 4.5% of the population in Cuyahoga County speak Spanish at home, and 4.6% speak an Indo-European language at home.

<sup>11</sup> American Community Survey, 2016-2020

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



County and state values- Claritas Pop-Facts (2022 population estimates), U.S. values- American Community Survey five-year (2016-2020) estimates

The most common languages spoken at home in Cuyahoga County are English (87.2%), followed by Indo-European languages - like French, Portuguese, Russian, Dutch (4.6%), and Spanish (4.5%).

# Social & Economic Determinants of Health

This section explores the economic, environmental, and social determinants of health impacting Cuyahoga County. Social determinants 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. The social determinants of health (SDOH) can be grouped into five domains. Figure 10 shows the Healthy People 2030 social determinants of health domains<sup>12</sup>.

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 neutral when examined at a higher level, zip code or census tract level analysis can reveal disparities.

<sup>12</sup> Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Retrieved [date graphic was accessed], from <https://health.gov/healthypeople/objectives-and-data/social-determinants-health>

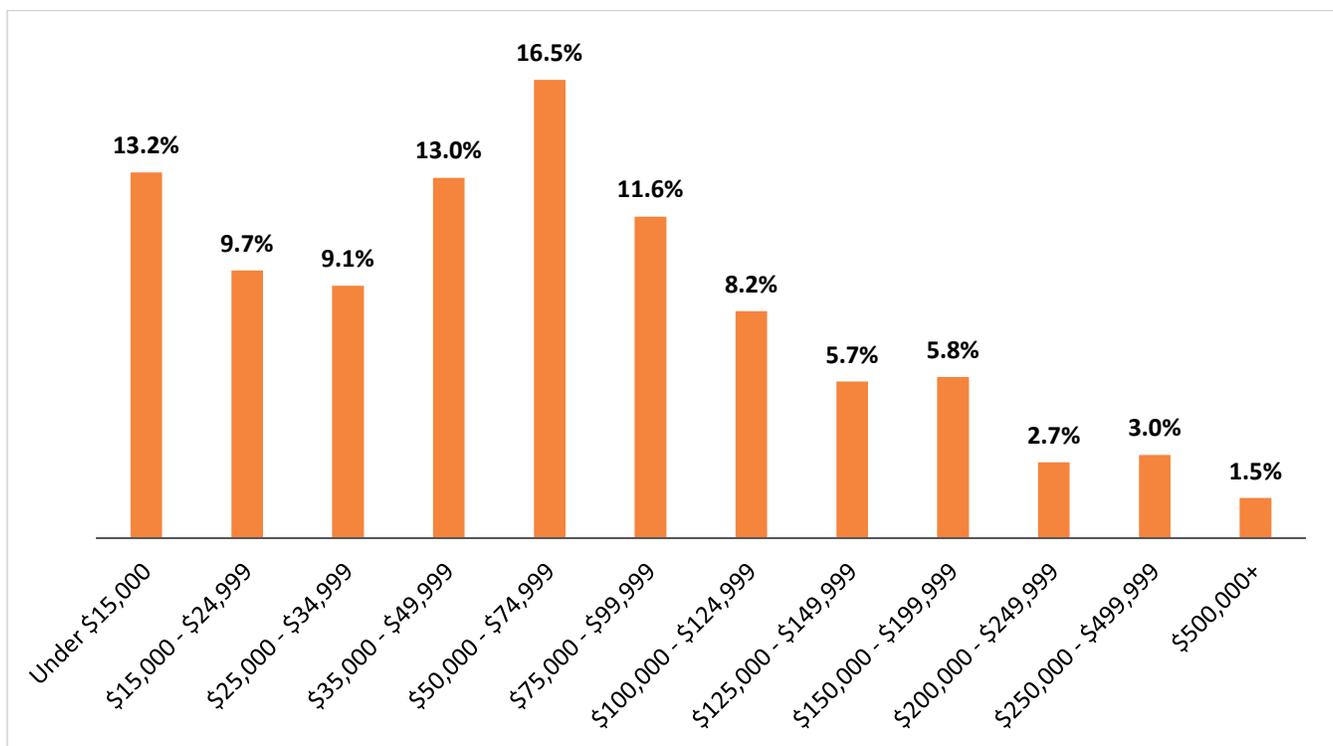
All demographic estimates are sourced from Claritas Pop-Facts (2022 population estimates) and American Community Survey one-year (2019) or five-year (2016-2020) estimates, unless otherwise indicated.

## Income

Income is strongly associated with morbidity and mortality, influencing health through various clinical, behavioral, social, and environmental factors. Similarly, those with greater wealth are more likely to have a 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.<sup>13</sup>

Figure 11 provides a breakdown of households by income in Cuyahoga County. The income range of \$50,000 - \$74,999 is shared by the largest proportion of households in Cuyahoga County (16.5%). Households with an income of less than \$15,000 make up 13.2% of all households in Cuyahoga County.

**Figure 11: Households by Income, Cuyahoga County**

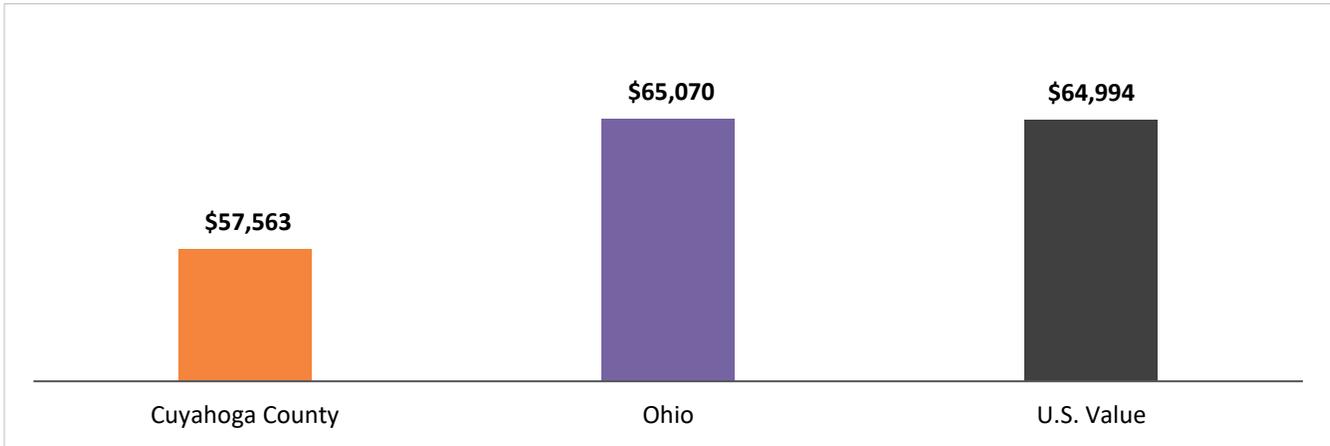


County values- Claritas Pop-Facts (2022 population estimates)

<sup>13</sup> 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>

The median household income for Cuyahoga County is \$57,563, which is lower than both the state value of \$65,070 and the U.S. value of \$64,994 (Figure 12).

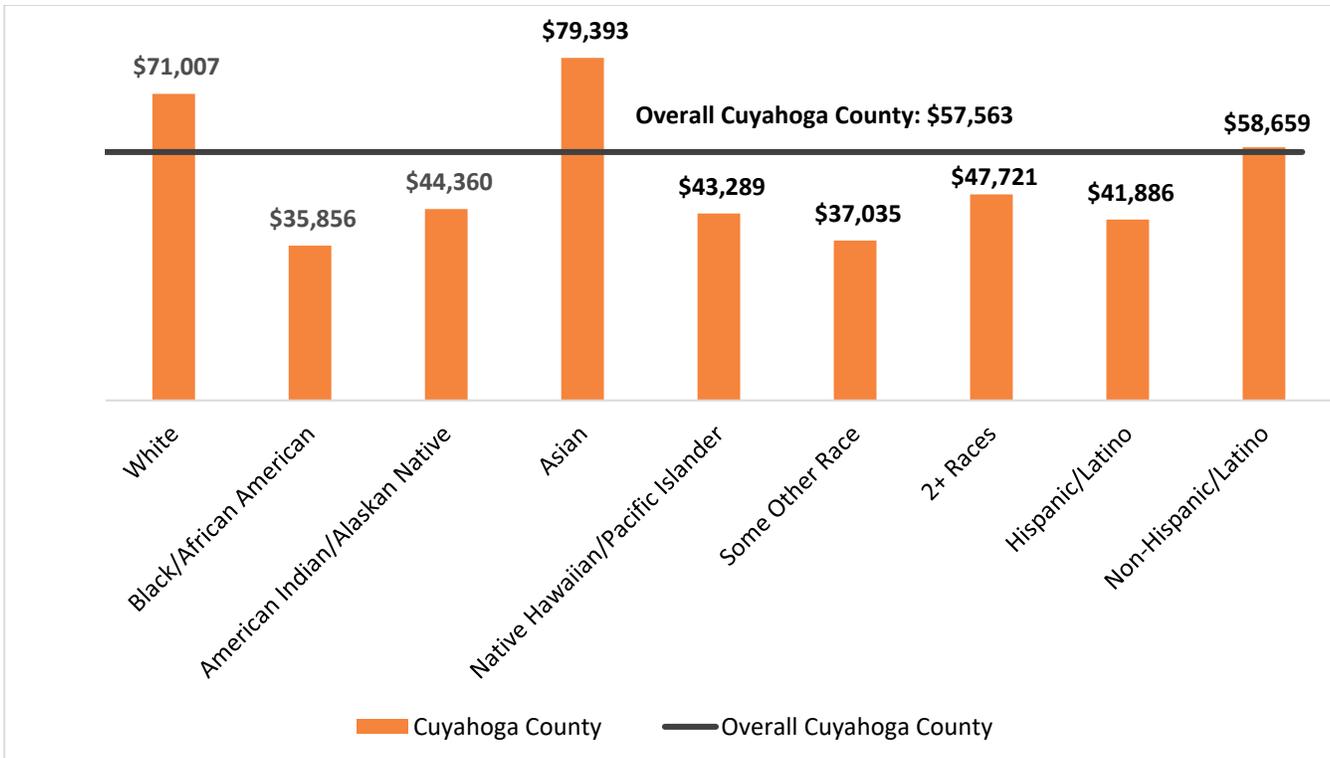
**Figure 12: Households by Median Income: County, State and U.S. Comparisons**



County and state values- Claritas Pop-Facts (2022 population estimates), U.S. values taken from American Community Survey five-year (2016-2020) estimates

Figure 13 shows the Median Household Income by Race and Ethnicity. Three racial/ethnic groups – White, Asian, and Non-Hispanic/Latino – have median household incomes above the overall median value, with Asian households having the highest median household income at \$79,393. All other races have incomes below the overall value, with Black/African American households having the lowest median household income at \$35,856.

**Figure 13: Median Household Income by Race/Ethnicity, Cuyahoga County**



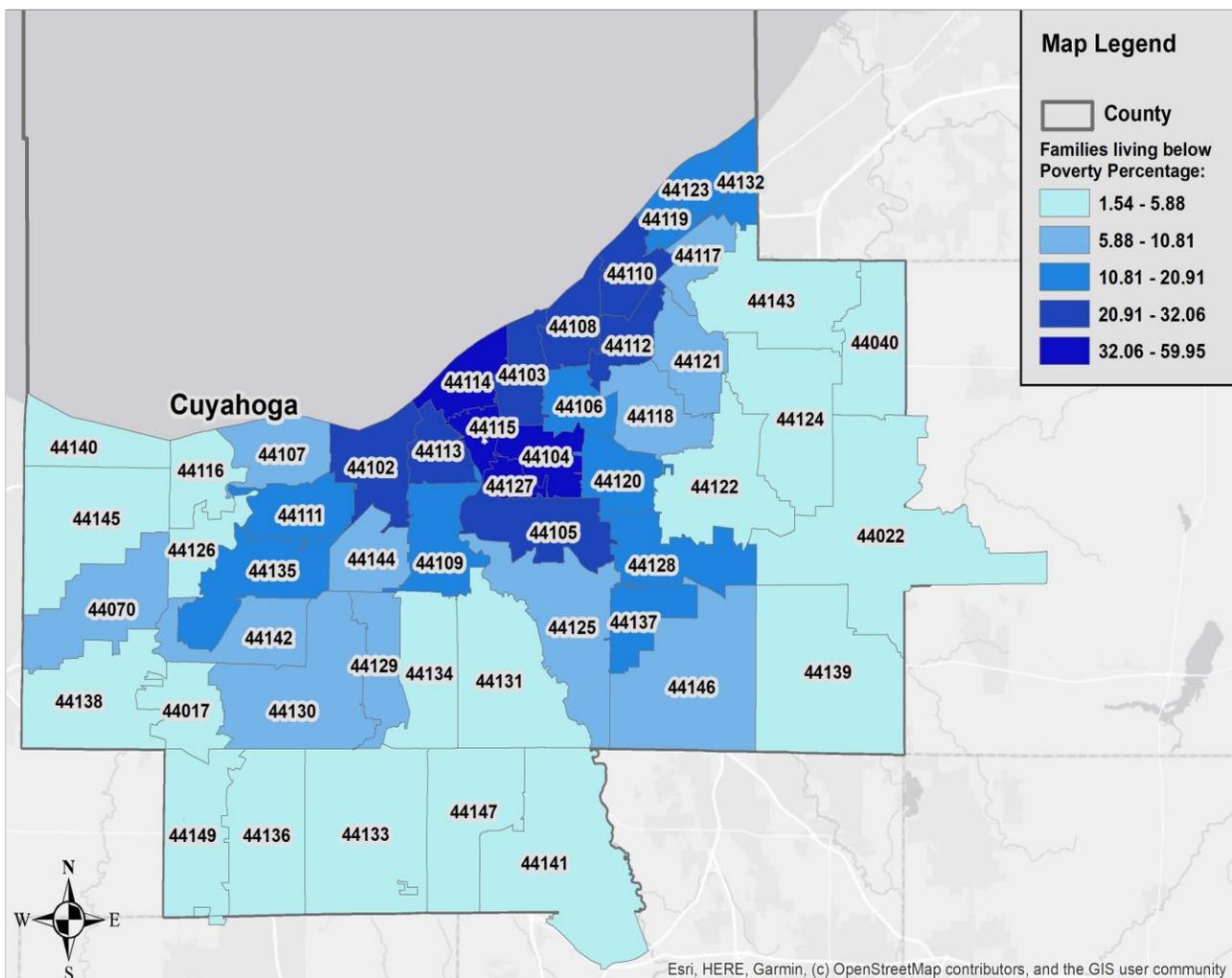
County values- Claritas Pop-Facts (2022 population estimates)

## Poverty

Federal poverty thresholds are set every year by the Census Bureau and vary by the number and age of adults and the number of children under age 18 in the family unit size of family. People living in poverty are less likely to have access to healthcare, healthy food, stable housing, and opportunities for physical activity. These disparities mean that people living in poverty are more likely to experience poorer health outcomes and premature death from preventable diseases.<sup>14</sup>

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 44115 and 44104 having the highest percentages at 60.0% and 47.5%, respectively. Overall, 11.9% of families in Cuyahoga County live below the poverty level, which is higher than both the state value of 9.6% and the U.S. of 9.1%. The percentage of Families Living Below Poverty for each zip code in Cuyahoga County is provided in [Appendix B](#) on page 153 of this report.

**Figure 14: Families Living Below the Poverty Level: Cuyahoga County Zip Codes**



<sup>14</sup> 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>

## Employment

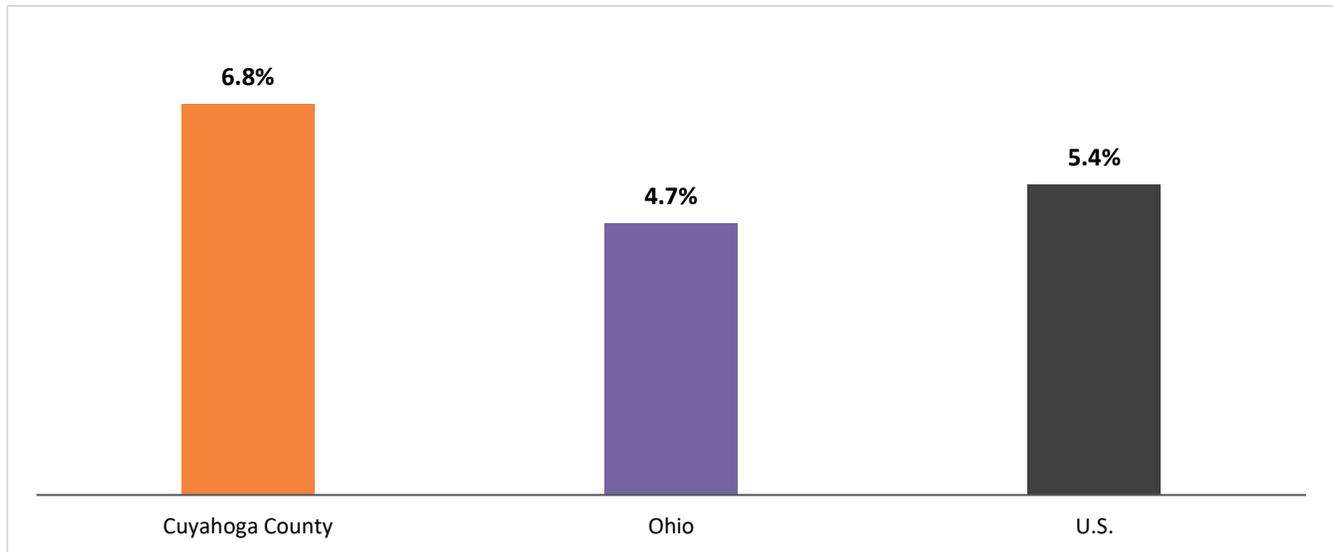
A community's employment rate is a key indicator of the local economy's status. An individual's type and level of employment also impacts access to healthcare, work environment, health behaviors and health outcomes. Stable employment can help provide benefits and conditions for maintaining good health.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

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.<sup>15</sup>

The type of employment and working conditions can also have significant impacts on health. Work-related stress, injury, and exposure to harmful chemicals are some examples of how employment can lead to poorer health.<sup>15</sup>

Figure 15 shows the Population Ages 16 and Over Who are Unemployed. The unemployment rate for Cuyahoga County is 6.8%, which is higher than the state value at 4.7% and the U.S. value at 5.4%.

**Figure 15: Population 16+ Unemployed**



County and state values- Claritas Pop-Facts (2022 population estimates), U.S. values- American Community Survey five-year (2016-2020) estimates

## Education

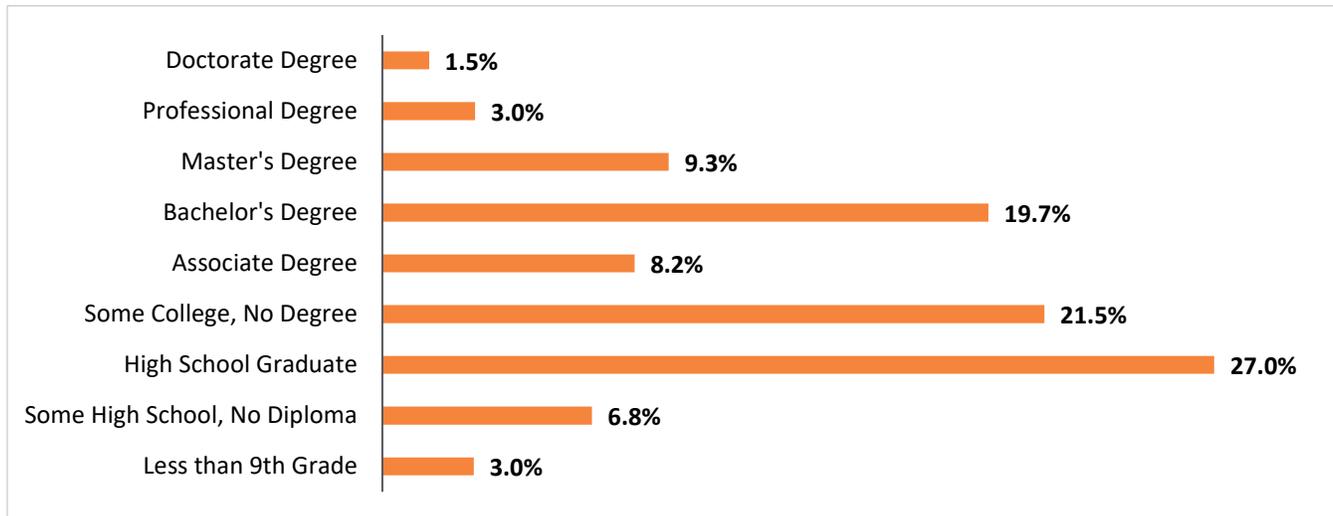
Education is another important indicator for health and wellbeing. Education can lead to improved health by increasing health knowledge, providing better job opportunities and higher income, and improving social and psychological factors linked to health. People with higher levels of education are likely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

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

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

Figure 16 shows the percentage of the Population 25 Years or Older by Educational Attainment in Cuyahoga County.

**Figure 16: Population 25+ by Educational Attainment, Cuyahoga County**

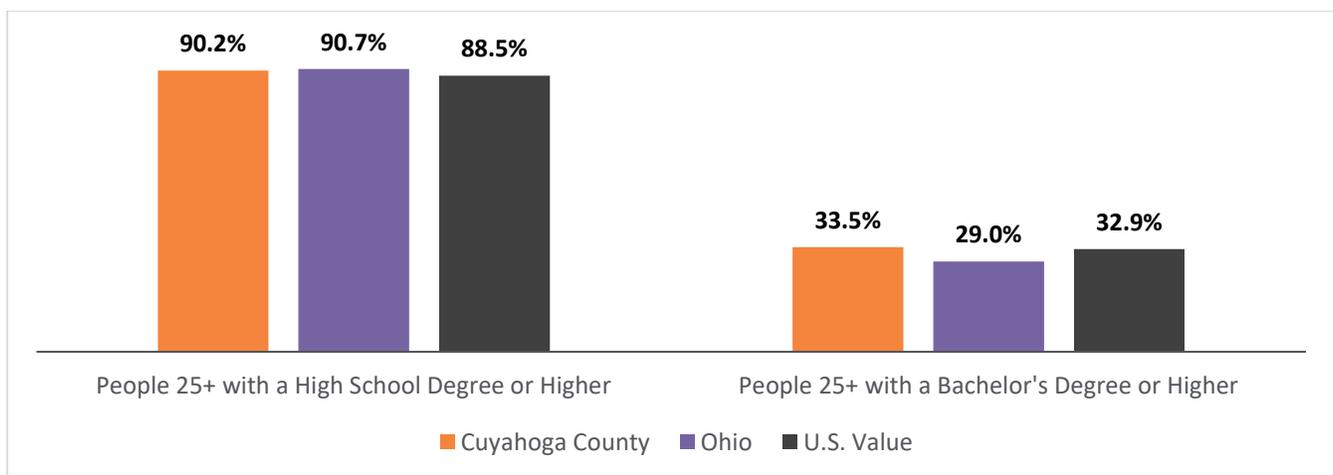


County values- Claritas Pop-Facts (2022 population estimates)

Another indicator related to education is on-time high school graduation. A high school diploma or its equivalent is a requirement for many employment opportunities and for higher education. Not graduating high school is linked to a variety of negative economic impacts, including limited employment prospects, low wages, and poverty.<sup>17</sup>

Figure 17 shows that Cuyahoga County has a higher percentage of Residents with a High School Degree or Higher (90.2%) when compared to the U.S. value (88.5%) but has a slightly lower percentage when compared to the State value (90.7%). However, Residents with a Bachelor's Degree or Higher (33.5%) make up a larger percentage of the population when compared to both the state (29.0%) and U.S. value (32.9%).

**Figure 17: Population 25+ by Educational Attainment: County, State, and U.S. Comparisons**



County and state values- Claritas Pop-Facts (2022 population estimates), U.S. values- American Community Survey five-year (2016-2020) estimates

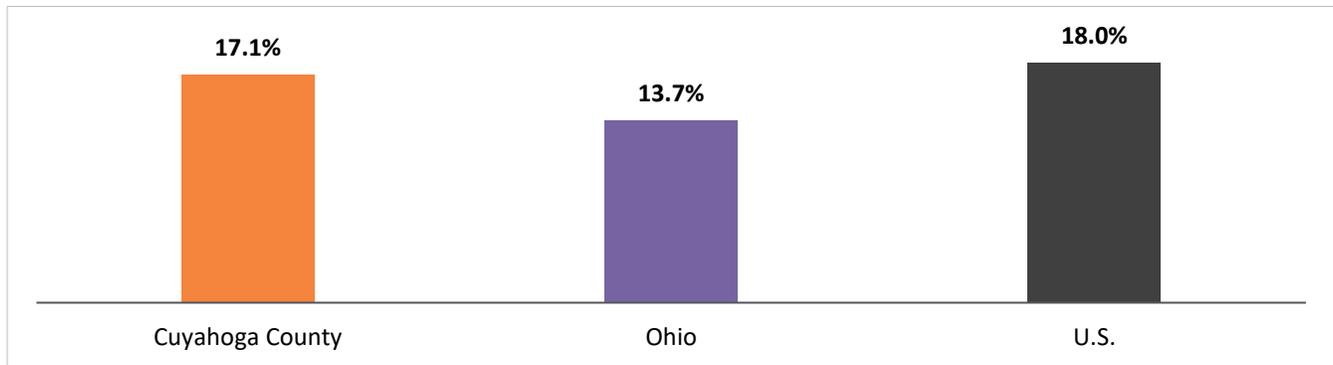
<sup>17</sup> U.S. Department of Health and Human Services, Healthy People 2030. <https://health.gov/healthypeople/objectives-and-data/social-determinants-health/literature-summaries/high-school-graduation>

## 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's or family's health.<sup>18</sup>

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 problems: overcrowding, high housing costs, lack of kitchen, or lack of plumbing facilities. In Cuyahoga County, 17.1% of households were found to have at least one of these problems, which is higher than the state value (13.7%), but lower than the U.S. value (18.0%).

**Figure 18: Percentage of Houses with Severe Housing Problems: County, State and U.S. Comparisons**

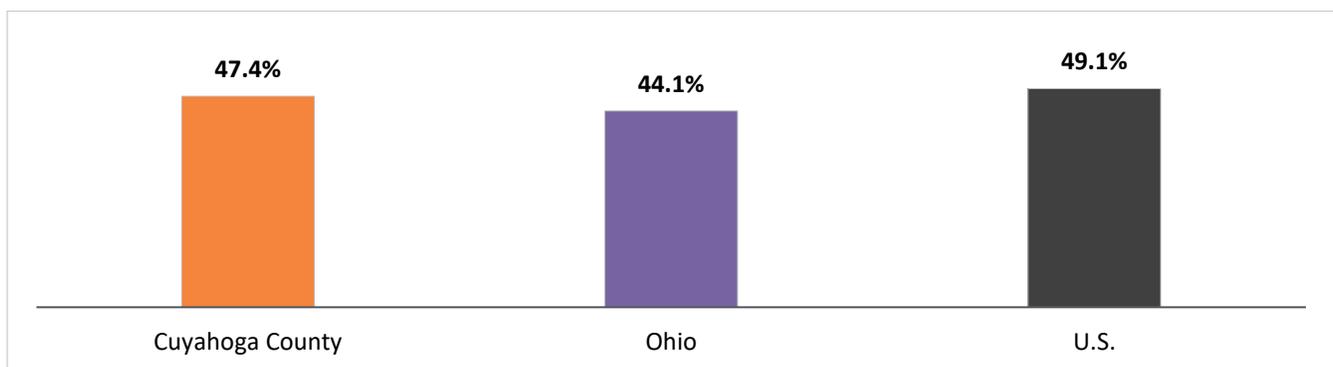


County, State, and U.S. values- County Health Rankings (2013-2017)

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.<sup>19</sup>

Figure 19 shows the percentage of Renters Who are Spending 30% or More of Their Household Income on Rent. The value in Cuyahoga County (47.4%), is lower than the U.S. value (49.1%), but is higher than the state value (44.1%).

**Figure 19: Renters Spending 30% or More of Household Income on Rent**



County, State, and U.S. values- American Community Survey five-year (2016-2020) estimates

<sup>18</sup> 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>

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

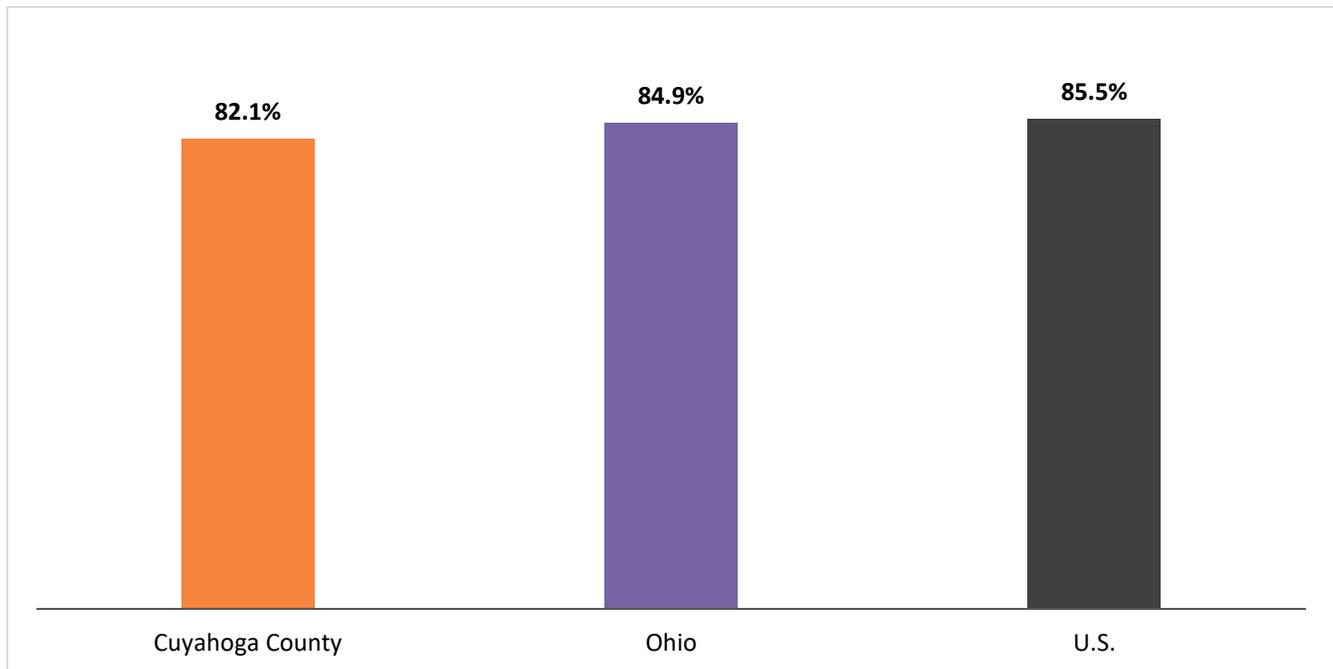
## Neighborhood and Built Environment

Internet access is essential for basic healthcare access, including making appointments with providers, getting test results, and accessing medical records. Access to the internet is also increasingly essential for obtaining home-based telemedicine services, especially during the Covid-19 pandemic, with isolation and social distancing regulations.<sup>20</sup>

Internet access may also help individuals seek employment opportunities, conduct remote work, and participate in online educational activities.<sup>20</sup>

Figure 20 shows the percentage of Households that have an Internet Subscription. The rate in Cuyahoga County (82.1%) is lower than the state value (84.9%) and the U.S. value (85.5%).

**Figure 20: Households with an Internet Subscription: County, State and U.S. Comparison**



County and state values- Claritas Pop-Facts (2022 population estimates), U.S. values- American Community Survey five-year (2016-2020) estimates

<sup>20</sup> 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>

# 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.<sup>21</sup> National trends have shown that systemic racism, poverty, and gender discrimination have led to poorer health outcomes for groups such as Black/African American persons, Hispanic/Latino persons, Indigenous persons, people with incomes below the federal poverty level, and LGBTQ+ communities.

## Race, Ethnicity, Age & Gender Disparities

Primary and secondary data revealed significant community health disparities by race, ethnicity, gender identity, sexual orientation, and age. It is important to note that much of the data is presented to show differences and disparities of data by population groups. For instance, Asian or Asian and Pacific Islander persons encompass 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 focus group 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<sup>22</sup> 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 B](#) on page 153 of this report.

Table 1 identifies secondary data indicators with a statistically significant race, ethnicity, or gender disparity for Cuyahoga County, based on the Index of Disparity.

**Table 1: Indicators with Significant Race, Ethnicity or Gender Disparities**

Health Indicator	Group(s) Negatively Impacted
Babies with Very Low Birth Weight	Black/African American
Children Living Below Poverty Level	Black/African American, White, Asian, Multiple Races, Hispanic/Latino
Families Living Below Poverty Level	Black/African American, White, Asian, American Indian/Alaska Native, Multiple Races, Hispanic/Latino

<sup>21</sup> 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](https://www.cdc.gov/nchs/ppt/nchs2010/41_klein.pdf)

<sup>22</sup> Percy, J. & Keppel, K. (2002). A Summary Measure of Health Disparity. Public Health Reports, 117, 273-280.

<b>People Living Below Poverty Level</b>	Black/African American, White, Asian, American Indian/Alaska Native, Native Hawaiian/Pacific Islander, Multiple Races, Other Race, Hispanic/Latino
<b>People 65+ Living Below Poverty Level</b>	Black/African American, White, Asian, American Indian/Alaska Native, Native Hawaiian/Pacific Islander, Multiple Races, Other Race, Hispanic/Latino
<b>Workers Commuting by Public Transportation</b>	Black-African American, White, Multiple Races, Hispanic/Latino
<b>Workers who Walk to Work</b>	Black-African American, White, Asian, Multiple Races, Other Race, Hispanic/Latino

The Index of Disparity analysis for Cuyahoga County reveals that the Black/African American and Latino/Hispanic populations are disproportionately impacted across various measures of Poverty which are often associated with poorer health outcomes. These indicators include Children Living Below Poverty Level, Families Living Below Poverty Level, People Living Below Poverty Level, People 65+ Living Below Poverty Level. Furthermore, the Black/African American population is also disproportionately impacted in Babies with Very Low Birth Weight. Finally, Black/African American, White, Asian, Multiple Races, and Hispanic/Latino populations are disproportionately impacted across measures of public transportation.

## Primary Data

Disparities by race, ethnicity, age & gender were also main points of discussion among focus group participants and key informants and are crucial when planning how to address the prioritized health needs identified through this CHNA. Disparities are explored more fully within the primary data sections below each [prioritized health need](#) (p. 51), [priority population](#) (p. 62) and [overarching focal areas](#) (p.67).

## 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 poorer mental health outcomes. 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

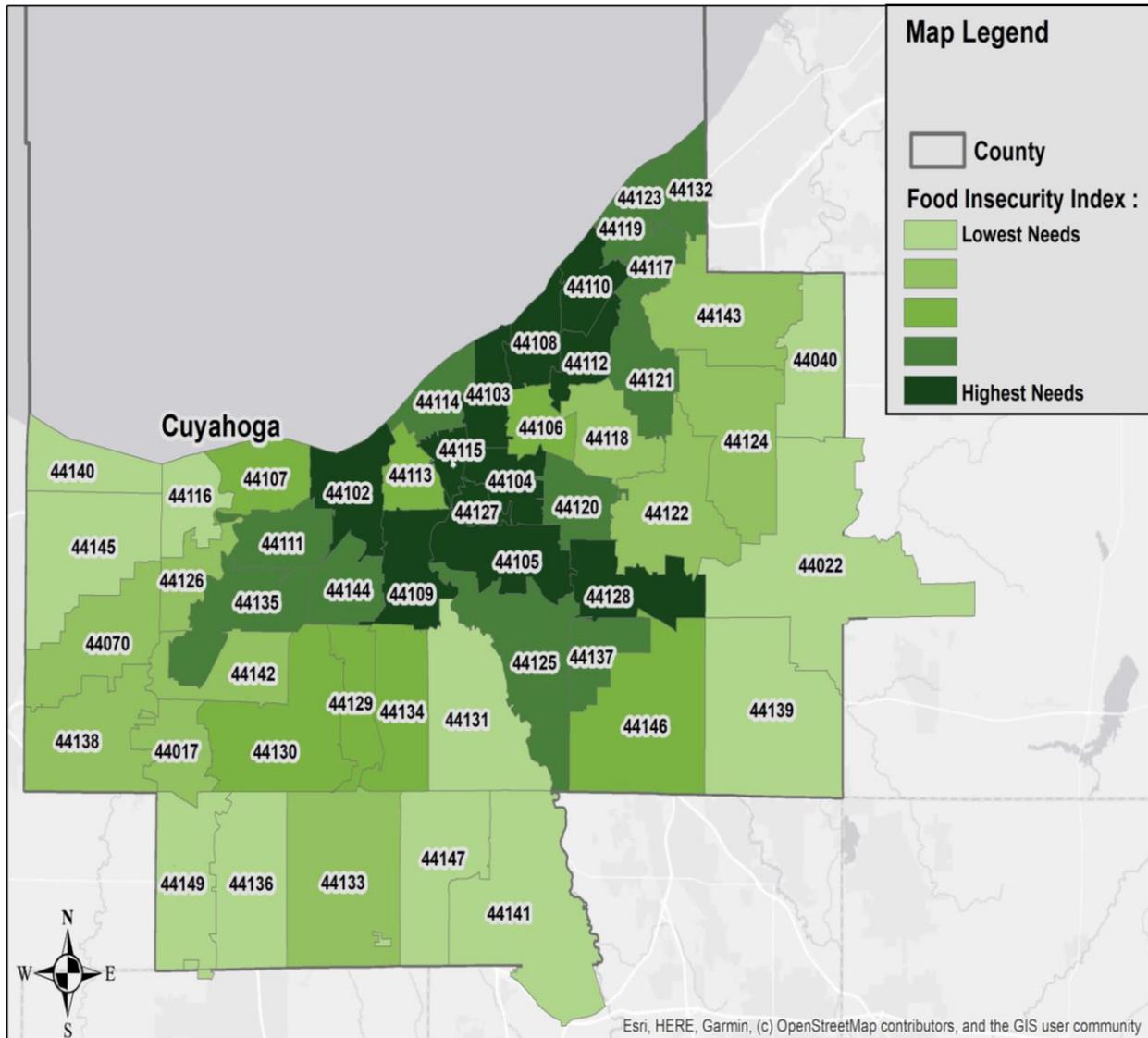
Conduent’s Health Equity Index estimates areas of high socioeconomic need, which are correlated with poor health outcomes. Zip codes are ranked based on their index value to identify relative levels of need, as illustrated by the map in Figure 21. The following zip codes in Cuyahoga County had the highest level of socioeconomic need (as indicated by the darkest shades of blue): 44104 and 44127 with index values of 99.9 and 99.8, respectively.



## Food Insecurity Index

Conduent's Food Insecurity Index 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): 44104 (Cleveland) and 44115 (Cleveland) with index values of 99.8 and 99.4, respectively.

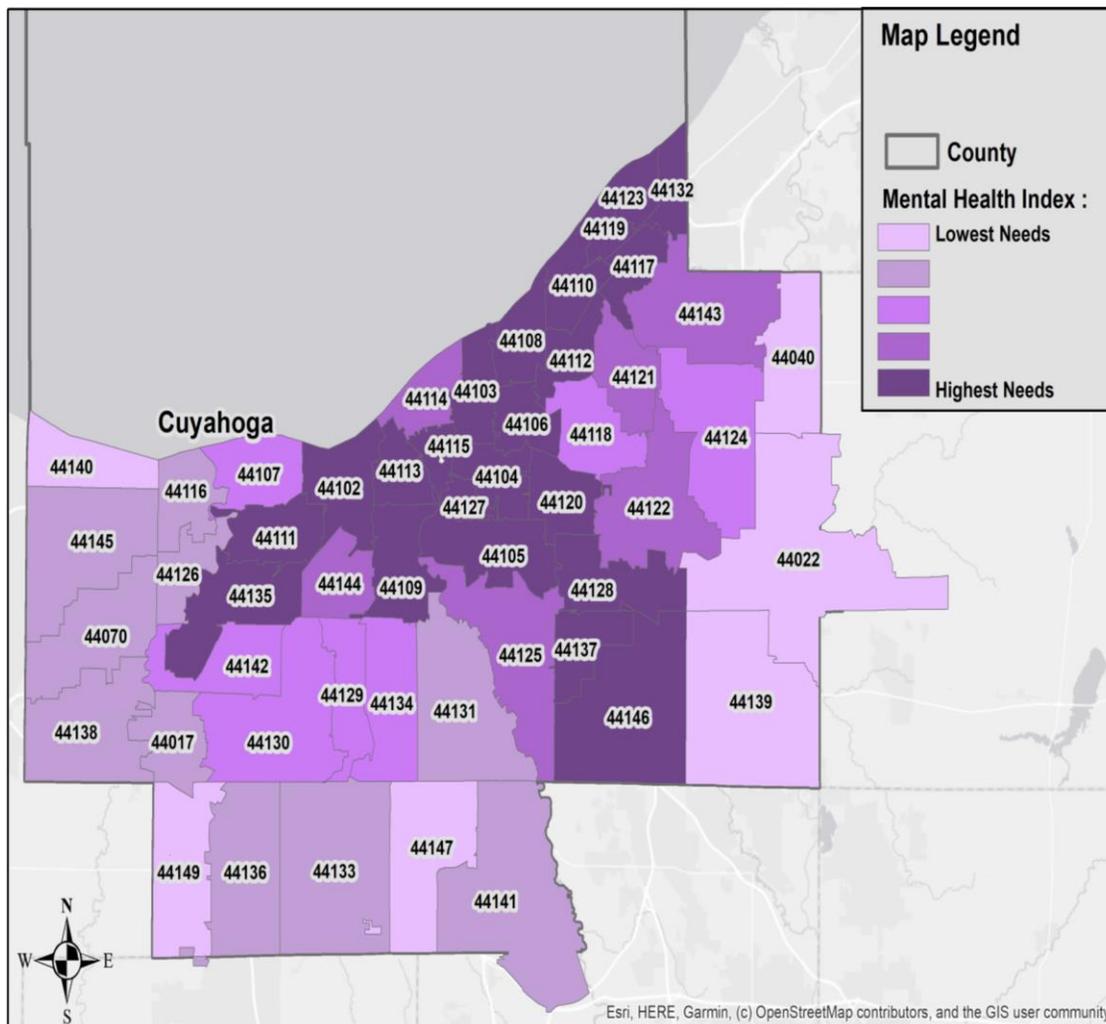
Figure 22: Food Insecurity Index



## Mental Health Index

Conduent’s Mental Health Index (MHI) is a measure of socioeconomic and health factors correlated with self-reported poor mental health. According to the MHI, in 2021, 44108 and 44104, each had an index value of 100. Other areas of high need, as indicated by the darkest shade of purple, are identified in Figure 23.

Figure 23: Mental Health Index



## Future Considerations

While disparities in health outcomes are critical components in assessing the needs of a community, it is equally important to understand the social determinants of health and other upstream factors that influence a community’s health. The challenges and barriers faced by a community must be balanced by identifying practical, community-driven solutions. Together, these factors come together to inform and focus strategies to positively impact a community’s health and mitigate the disparities in Cuyahoga County.

# Primary and Secondary Data Methodology and Key Findings

## Secondary Data Sources & Analysis

Secondary data used for this assessment were collected and analyzed from the Healthy Northeast Ohio (NEO) community data platform. [Healthy NEO](#) is a publicly available website which houses neutral population health data and community health resources to support community health improvement efforts across a 9-county region. The data on this platform, maintained by researchers and analysts at Conduent HCI, includes over 200 community indicators, spanning at least 24 topics in the areas of health, 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, national targets, and to previous time periods.

HCI’s Data Scoring Tool systematically summarizes multiple comparisons and ranks indicators based on highest need. For each indicator, Cuyahoga County value was compared to a distribution of Ohio and U.S. counties, state and national values, Healthy People 2030 targets, and significant trends, as shown in Figure 24. Each indicator was then given a score based on the available comparisons. These scores range from 0 to 3, where 0 indicates the best outcome and 3 indicates the poorest outcome. Availability of each type of comparison varies by indicator and is dependent upon the data source, comparability with data collected from other communities, and changes in methodology over time. These indicators were grouped into topic areas for a higher-level ranking of community health needs.

Due to the limited availability of zip code, census tract, or other sub-county health data, the data scoring technique is only available at the county level. The data scoring results are therefore presented in the context of Cuyahoga County.

Table 2 shows the health and quality of life topic scoring results for Cuyahoga County, with Prevention & Safety as the poorest performing topic area with a score of 2.09, followed by Other Conditions (which include other health conditions such as Kidney Disease, Osteoporosis, and Arthritis) with a score of 1.83. Topics that received a score of 1.50 or higher were considered a significant health need. Twelve topics scored at or above the

Figure 24. Secondary Data Scoring

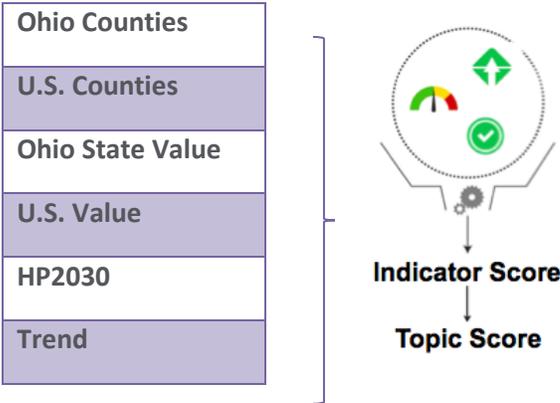
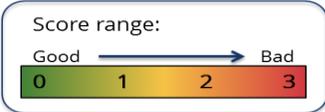


Table 2. Topic Scoring Results

Health & Quality of Life Topics	Score
Prevention & Safety	2.09
Other Conditions	1.83
Alcohol & Drug Use	1.74
Children's Health	1.72
Medications & Prescriptions	1.72
Cancer	1.71
Economy	1.70
Older Adults	1.68
Community	1.63
Maternal, Fetal & Infant Health	1.55
Education	1.53
Environmental Health	1.53



threshold. Topic areas with fewer than three indicators were considered a data gap. Please see [Appendix B](#) (p. 153) for the full list of health and quality of life topics, including the list of national and state indicators that are categorized into and included in the secondary data analysis for each topic area. Further details on the quantitative data scoring methodology are also available in [Appendix B](#) (p. 153).

### Community Feedback: Primary Data Collection & Analysis

To ensure the perspectives of community members were considered, input was collected from Cuyahoga County community members. Primary data used in this assessment consisted of key informant interviews (KIIs) with community stakeholders and community focus groups. These findings expanded upon information gathered from the secondary data analysis to inform this Cuyahoga County CHNA.

### Qualitative Data: Key Informant Interviews & Focus Groups

#### Key Informant Interviews

Conduent Healthy Communities Institute (HCI) conducted key informant interviews via phone and video conference in order to collect community input. Interviewees invited to participate were recognized as having expertise in public health, special knowledge of community health needs, and/or being able to speak to the needs of underserved or vulnerable populations. Thirty-two individuals participated as key informants representing different entities serving Cuyahoga County. Table 3 lists the represented organizations that participated in the interviews.

**Table 3. Cuyahoga County Key Informant Organizations**

Key Informant Organizations	
<ul style="list-style-type: none"> <li>ADAMHS Board of Cuyahoga County</li> <li>Asian Services in Action (ASIA)</li> <li>Benjamin Rose Institute on Aging</li> <li>Better Health Partnership</li> <li>Calvary Hill Church of God in Christ</li> <li>Center for Community Solutions</li> <li>Centers for Families &amp; Children</li> <li>City of Cleveland Division of Emergency Medical Services (EMS)</li> <li>Cleveland Clinic Lakewood Family Health Center</li> <li>Cleveland Department of Public Health (CDPH)</li> <li>Cuyahoga County Board of Health (CCBH)</li> <li>Cuyahoga County HHS</li> </ul>	<ul style="list-style-type: none"> <li>Educational Service Center of NEO</li> <li>Esperanza, Inc</li> <li>FrontLine Service</li> <li>Greater Cleveland Food Bank</li> <li>Greater Cleveland Regional Transit Authority (RTA)</li> <li>Hispanic Roundtable</li> <li>LGBT Community Center</li> <li>May Dugan Center</li> <li>NAMI Greater Cleveland</li> <li>Neighborhood Family Practice</li> <li>Policy Bridge</li> <li>Positive Education Program (PEP)</li> <li>Taylor Oswald</li> <li>University Hospitals - Pediatric/Women's</li> </ul>

<ul style="list-style-type: none"> <li>• Cuyahoga County Office of Homeless Services</li> <li>• Cuyahoga Metropolitan Housing Authority (CMHA)</li> </ul>	<ul style="list-style-type: none"> <li>• Urban League of Greater Cleveland</li> </ul>
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The thirty-two key informant interviews took place between May and June 2022 via phone or video conference. The questions focused on the interviewee’s background and organization, the greatest perceived health needs and barriers of concern in the community and the impact of health issues on the populations they serve and other vulnerable populations. Interviewees were also asked about their knowledge around health topics where there were data gaps in the secondary data. Key Informants were also asked to list and describe resources available in the community and although not reflective of every resource available in the community, the list can help the Cuyahoga County CHNA Steering Committee build partnerships so as not to duplicate, but rather support existing programs and resources. This resource list is available in the [Community Resources Available to Potentially Address Needs](#). Additionally, questions were included to obtain feedback about the impact of COVID-19 on their community. A list of the questions asked in the key informant interviews can be found in [Appendix C](#) on page 201 of this report.

**Focus Groups Methodology**

Focus groups were also conducted by Cuyahoga County CHNA Steering Committee partners, University Hospitals and The Center for Health Affairs. The purpose of these facilitated group conversations was to gain deeper insights about perceptions, attitudes, experiences, or beliefs held by community members about their health and the health of their community. The data collected through the focus group process provides adjunct information to the quantitative data collection methods in a mixed methods approach. While the data collected is useful in gaining insight into a topic that may be more difficult to gather through other data collection methods, it is important to note that the information collected in an individual focus group is not necessarily representative of other groups.

The project team developed a focus group guide made up of a series of questions and prompts about the health and well-being of residents in Cuyahoga County (see [Appendix C](#) p. 201). Community members were asked to speak to barriers and assets to their health and access to healthcare. Three in-person discussions were hosted in August 2022. Discussions lasted approximately 60 to 90 minutes. Facilitators implemented techniques to ensure that everyone was able to participate in the discussion. Participants were recruited for the focus group sessions through community partner organizations. Key community groups who participated in these focus groups include representatives from: 1) Older Adults who identify as LGBTQ+ as well as LGBTQ+ Allies; 2) Individuals who identify as Transgender and Nonbinary; and 3) Youth who identify as LGBTQ+.

**Qualitative Analysis Results**

The facilitators captured detailed notes and transcripts of the key informant interviews and focus group sessions. The text from these transcripts were analyzed using the qualitative analysis program Dedoose<sup>23</sup>. Text was coded using a pre-designed codebook, organized by themes, and analyzed for significant observations. The findings from the qualitative analysis will be combined with the findings from other data sources and incorporated into the Data Synthesis and Prioritized Health Needs of the CHNA Report.

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<sup>23</sup> Dedoose Version 8.0.35, web application for managing, analyzing and presenting qualitative and mixed method research data (2018). Los Angeles, CA: SocioCultural Research Consultants, LLC [www.dedoose.com](http://www.dedoose.com)

Table 4 below summarizes the top health and quality of life categories that were identified from the key qualitative data analysis. These top need areas were synthesized with findings from secondary data analysis to identify overall health needs for consideration for prioritization in Cuyahoga County.

**Table 4. Cuyahoga County Top Needs Identified Through Qualitative Data Analysis**

- Accessible and Affordable Healthcare
- Access to Healthy Food
- Behavioral Health
- Community Safety
- Economy
- Education
- Environmental Health
- Maternal, Fetal, & Infant Health
- Older Adults
- Structural and Institutional Racism

### Data Considerations

A key part of any data collection and analysis process is recognizing potential limitations within the data considered. Each data source used in this assessment was evaluated based on its strengths and limitations during data synthesis and should be kept in mind when reviewing this report.

For both primary and secondary data, immense efforts were made to include as wide a range of community health indicators, key informants, and focus group participants as possible. Although the topics by which data are organized cover a wide range of health and quality of life areas, within each topic there is a varying scope and depth of secondary data indicators and primary data findings.

Secondary data were limited by the availability of data, with some health topics having a robust set of indicators, while others were more limited. Population health and demographic data are often delayed in their release, so data is presented for the most recent years available for any given data source. There is also variability in the geographic level at which data sets are available, ranging from census tract or zip code to statewide or national geographies. Whenever possible, the most relevant localized data is reported. Due to variations in geographic boundaries, population sizes, and data collection techniques for different locations (hospital service areas, zip codes, and counties), some datasets are not available for the same time spans or at the same level of localization. Finally, persistent gaps in data exist for certain community health issues. For example, ample secondary data is still lacking for the LGBTQ+ community. Indicators and data collected and maintained for Maternal, Infant, and Child health can vary greatly as well across states and at the local level.

For the primary data, the breadth of findings is dependent upon who self-selected to participate as key informants and focus group participants.

# Cuyahoga County Health Concerns

## Overview

Multiple types of data were collected and analyzed to inform this Community Health Needs Assessment. They include the following data collection activities:

- Secondary Data Analysis of over 200 community indicators, spanning at least 24 topics in the areas of health, determinants of health, and quality of life
- Thirty-two informant interviews with key community partners
- Three community focus groups with Cuyahoga County residents

## Significant Health Needs

Findings from the data sources described above were analyzed and combined to identify the significant health needs for Cuyahoga County. Figure 25 illustrates the ten significant health needs, listed in alphabetical order, that were included for prioritization based on the findings of all forms of data collected for Cuyahoga County 2022 CHNA.

Figure 25. Cuyahoga County Significant Health Needs



# Prioritization

To better target activities to address the most pressing health needs in the community, the Cuyahoga County CHNA Steering Committee convened a group of community members and leaders to participate in two virtual presentations of data on significant health needs facilitated by Conduent HCI. Following the data presentation and facilitated discussion, participants participated in a prioritization voting activity.

Following the community prioritization, members from the Cuyahoga County CHNA Steering Committee completed an additional review, discussion, and scoring while considering the results of the community prioritization as well as alignment with the Ohio SHIP. Final scoring of the ten significant community health needs resulted in the identification of three priority areas to be considered for subsequent implementation planning.

## Process

Invitations to participate in the two Cuyahoga County data synthesis presentations and virtual prioritization activities were sent out in the weeks preceding the meetings held on Tuesday, August 2, 2022 and Thursday, August 4, 2022. A total of 118 individuals representing local hospital systems, health departments, educational institutions as well as community-based organizations, nonprofits, and the general community attended the virtual meetings. A central piece of the day's proceedings was a presentation and conversation to center equity in the discussion and considerations for the data presentation and prioritization activity. Documents were shared with participants ahead of the meeting to support this discussion. These handouts can be found in [Appendix C](#) on page 201 of this report.

During the two virtual meetings, the groups reviewed and discussed the results of the primary and secondary data analyses leading to the ten significant health needs. Participants were given a set time during the end of the session to participate in the prioritization voting. During this activity, each voted on the significant health needs based on how well they met the criteria set forth by the Cuyahoga County CHNA Steering Committee.

The criteria for prioritization included:

- 1. Magnitude of the Problem:** How BIG an issue is each health issue?
  - How many people in the community are or will be impacted?
  - How does each need impact health and quality of life?
  - Has the need changed over time?
- 2. Ability to Impact:** Do you feel the groups taking on this work will be able to have a positive impact on each health issue?
  - Do the hospitals, health departments, or community organizations have the knowledge, experience or resources to address the health need?
  - Can the need be addressed in collaboration with community partners? Are organizations already addressing the health issue?
  - Can we create clear goals to address the health need? Are those goals achievable in the next few years?
- 3. Inequities & Social Determinants of Health:** Do inequities exist or is there influence of any social or economic factors?

- Do inequities exist for each health issue?
- Are there Social Determinants of Health that influence this health issue to be better or worse?
- Does this issue impact some populations or communities more than others?

In addition to considering the data presented by Conduent HCI, participants were encouraged to use their own knowledge, judgement, and lived experience as well as considering how well a health topic met the criteria.

In a separate process following the community-facing Prioritizations, the Cuyahoga County CHNA Steering Committee partner agencies met to conduct their own individual entity vote to prioritize the significant health needs.

The partner agency criteria included:

- Magnitude of the Problem
- Severity of the Problem
- Inequities & Social Determinants of Health
- Magnitude of the Health Disparity
- Priorities Determined by Community
- Alignment with SHA/SHIP

Ultimately, the overall voting results were combined to produce a final list of significant health needs in ranked order. The Cuyahoga County CHNA Steering Committee then reviewed and discussed the scoring results of the prioritized significant community needs and identified three priority areas to be considered for subsequent implementation planning. The results of the overall Prioritization Results are shown in Table 5.

**Table 5. Overall Prioritization Activity Results**

Rank	Significant Health Need Area
1	Behavioral Health (Mental Health and Drug Use/Misuse)
2	Structural and Institutional Racism
3	Accessible and Affordable Healthcare
4	Access to Healthy Food
4	Community Safety
5	Maternal, Fetal, & Infant Health
6	Economic Concerns
7	Environmental Health
8	Older Adults
9	Education

## Prioritized Significant Health Needs

From the final scoring of the ten significant community health needs, three priority areas were identified to be considered for integration into the Community Health Improvement Planning process. These included combining the categories of Mental Health and Substance Use and Misuse into the broader category of Behavioral Health. Access to Healthy Foods and Community Safety were also combined into a broader Community Conditions category (Figure 26).



In addition to these three prioritized health need categories, two prioritized populations were identified including Maternal, Fetal, and Infant Health as well as the Older Adult population. Finally, Eliminating Structural Racism and Enhancing Trust and Trustworthiness across sectors, people, and communities will continue to be two overarching focal areas for work in Cuyahoga County. A deeper dive into primary and secondary data for each of these priority areas is provided in the following section of the report. This information highlights how each topic became a priority area for Cuyahoga County.

# Prioritized Health Needs

The following section provides a detailed description of each prioritized health need. An overview is provided for each health topic, followed by a table highlighting the poorest performing indicators and a description of key themes that emerged from community feedback. The three prioritized health needs are presented in alphabetical order.

Each prioritized health topic includes key themes from community input and secondary data warning indicators. The warning indicators shown for certain health topics are above the 1.50 threshold for Cuyahoga County and indicate areas of concern. A legend is available in [Appendix B](#) on page 158 for how to interpret the distribution gauges and trend icons used within the data scoring results tables.

## Prioritized Health Topic #1: Behavioral Health (Mental Health & Drug Use/Misuse)

### Mental Health



- Identified as a significant health need through **secondary data analysis**, and from **key informants**
- Alzheimer's Disease or Dementia: Medicare Population was identified as an area of concern from secondary data analysis

#### Key Themes from Community Input

- LGBTQ+ population has been significantly impacted by COVID-19 due to the exacerbation of existing health disparities (mental health issues became worse when people were isolated)
- Impact of COVID-19 on Mental Health; stress, anxiety and trauma
- Specific impact on older adult population and children/youth

# Drug Use/Misuse



- Identified as a significant health need through **secondary data analysis**, and from **key informants**
- Areas of concern identified through the secondary data analysis include:
  - Death Rate due to Drug Poisoning
  - Alcohol-Impaired Driving Deaths
  - Adults who Drink Excessively
  - Age-Adjusted Drug and Opioid-Involved Overdose Death Rate
  - Consumer Expenditures: Tobacco and Legal Marijuana

## Key Themes from Community Input

- COVID-19 worsened mental health issues as people were isolated leading to increased drinking and smoking
- Overcoming stigma of seeking/receiving care
- Should be included with primary care
- Labor shortages of qualified staff as need increases

## Secondary Data

Behavioral Health is a health topic that is analyzed from Mental Health & Mental Disorders, and Alcohol & Other Drug Use secondary data health topics. From secondary data scoring results, Mental Health & Mental Disorders ranked 16<sup>th</sup> out of all topic areas while, Alcohol & Other Drug Use ranked 3<sup>rd</sup> out of all topic areas. Further analysis was done to identify specific indicators of concern. Those indicators with high data scores (at or above the threshold of 1.50) were categorized as indicators of concern and are listed in Table 6 below. See [Appendix B](#) on page 153 for the full list of indicators categorized within this topic.

**Table 6. Data Scoring Results for Behavioral Health (Mental Health and Drug Use/Misuse)**

SCORE	Behavioral Health	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			
2.44	Alcohol-Impaired Driving Deaths	41.4	28.3	32.2	27			
2.17	Alzheimer's Disease or Dementia: Medicare Population	11.4	--	10.4	10.8			
2.00	Adults who Drink Excessively	19.6	--	18.5	19			--
2.00	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate	39.2	--	40.4	23.5			--
1.83	Age-Adjusted Death Rate due to Suicide	14.2	12.8	14.7	13.9			

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			--
1.67	Consumer Expenditures: Alcoholic Beverages	637.1	--	651.5	701.9			--

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

Death Rate due to Drug Poisoning and Alcohol-Impaired Driving Deaths are top areas of concern related to Behavioral Health in Cuyahoga County. The death rate per 100,000 population due to drug poisoning, in Cuyahoga County is 42.6, which falls in the lower 50% of counties in Ohio, in the lower 25% of counties in the nation, and is showing definite concern in the community as the trend over time displays significant increase in Death Rate due to Drug Poisoning in Cuyahoga County. Alcohol-Impaired Driving Deaths measures the percentage of motor vehicle crash deaths with alcohol involvement, which is 41.4% in Cuyahoga County, and falls in the lower 25% of counties in the state and the nation respectively. And, while the indicator is showing a decreasing trend over time, it is statistically insignificant for Cuyahoga County.

## Primary Data

Mental Health was a top health need identified by key informants and focus group participants in this CHNA process. The impact of COVID-19 on mental health issues was a large topic of discussion across key informant and focus group conversations. In particular, the impact of increased stress, anxiety, and trauma that everyone has experienced throughout the pandemic. Participants noted that the mental health of older adults, children and youth were specifically impacted.

Social isolation was mentioned as a contributing factor to a person’s overall mental health and wellbeing and that isolation has further impacted populations within the community who were already isolated, like older adults and the LGBTQ+ population. Social isolation during COVID-19 has only exacerbated this. Participants explained that while resources such as a suicide hotline is available, “loneliness and depression can be silent killers”. Participants offered feedback that having access to inclusive, supportive environments helps individuals overcome social isolation.

Stress can be compounded for transgender and non-binary individuals because of their experience navigating systems that invalidate their “authentic” identity. These individuals are constantly asked to prove their “true selves”.

Access to affordable and timely mental health services was discussed as barriers to care that need to be considered and addressed. Youth focus group participants called for reliable mental healthcare, especially in schools. They explained that support tends to be more focused on “guidance” for student schedules instead of mental health support.

When speaking about behavioral health in general, the barriers of overcoming stigma to seek services or care for mental health or alcohol or substance misuse were mentioned. The challenge of receiving services from non-affirming providers was also mentioned as a barrier to accessing care.

Community members also discussed the need to better integrate behavioral healthcare within primary care as a way to address barriers. Another solution discussed by community members was providing more community-based mental health services. An additional barrier that was discussed, particularly among key informants, was labor shortages of qualified staff as the need for Behavioral Health services increase. The quotes below further highlight the key themes discussed in the qualitative data.

.....  
In the last two years we've learned that we have to meet the non-academic needs...increase in behavioral health needs among students, for example 8th graders who went into the pandemic but are coming back as 10th graders without that transitional period or learning how to be a highschooler.  
- Key Informant  
.....

.....  
The LGBTQ+ population has been significantly impacted by COVID-19. A lot of that has to do with the exacerbation of existing health disparities. For example, mental health issues became worse when people were isolated. People at home began drinking more and smoking more and gaining weight and engaging in unhealthy behaviors.  
- Key Informant  
.....

## Prioritized Health Topic #2: Accessible and Affordable Healthcare

# Accessible and Affordable Healthcare



- #1 health need identified in **community feedback**
- The following were identified as areas of concern from secondary data analysis
  - Adults with Health Insurance: 18+
  - Consumer Expenditures: Medical Services
  - Consumer Expenditures: Medical Supplies

### Key Themes from Community Input

- Trust is an issue that needs to be addressed
- More culturally competent care by providers who look like or have similar lived experiences to the patients they see
- Need to address health literacy/knowledge gaps through education and outreach
- Fear of seeking medical services within LGBTQ+ community

### Secondary Data

From secondary data scoring results, Medications & Prescriptions ranked 5<sup>th</sup> in the data scoring of all topic areas. 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 are listed in Table 7 below. See [Appendix B](#) (p. 153) for the full list of indicators categorized within this topic.

**Table 7. Data Scoring Results for Accessible and Affordable Healthcare**

SCORE	Accessible and Affordable Healthcare	Cuyahoga County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties
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.

Adults with Health Insurance, Consumer Expenditures: Medical Services, and Consumer Expenditures: Medical Supplies are top areas of concern related to Accessible and Affordable Healthcare in Cuyahoga County. The percentage of Adults with Health Insurance is 89.8% in Cuyahoga County, which falls in the lower 50% of counties in both Ohio and the U.S. The indicator Consumer Expenditures for Medical Services shows the annual dollar amount spent on medical services. The value of this indicator for Cuyahoga County which is \$1057.60, places the county in the lower 50% of counties for Ohio, while it falls in the lower 25% counties in the nation. Furthermore, Consumer Expenditures for Medical Supplies in Cuyahoga County is \$199.20. This places Cuyahoga County in the lower 50% of counties in Ohio, and in the lower 25% counties in the nation for this indicator.

## Primary Data

Accessible and Affordable Healthcare was the number one health need identified through qualitative community feedback by key informants and focus group participants. General trust in the healthcare system and with providers was specifically mentioned as an issue that needs to be addressed. Community members explained that more culturally competent care is needed and that one way to address this would be training and employing healthcare providers who look like or have similar lived experiences as the patients they see. Offering more inclusive spaces, especially in more rural communities was also mentioned as a way to address barriers to care. A particular example offered by LGBTQ+ focus group participants included having more inclusive language in all public spaces. Community respondents also spoke of the need to have more accessible communication with their care providers. Ensuring support through patient advocacy measures and additional personnel were also mentioned as resources that could help address barriers to access.

An additional theme trending through qualitative conversations was the need to address the barriers of health literacy and knowledge gaps in the community through increased outreach and education. Youth focus group participants recommended having more accessible health information in schools. They argued that “this is the primary way youth receive health information”. Youth also called for more accessible and affordable after school programs for themselves and their peers.

Focus group participants who identified as LGBTQ+ recommended that a gay/affirming healthcare provider list be created so that LGBTQ+ people have a resource to help them easily identify whether they are in a safe space in healthcare settings. Something as simple as displaying a pride flag can demonstrate that there are people there who have undergone training or identify similarly. Additionally, Trans and non-binary focus group participants spoke of the need to have an easier time accessing gender-affirming medical services. That care access is particularly challenging for individuals who do not have transportation or in-network health insurance coverage. One participant shared that it is frustrating “having to pay for healthcare that doesn’t respect you”. The quotes below further highlight the key themes discussed in the qualitative data.

.....  
I think there's a big issue with trust of large healthcare institutions in communities of poverty. Well, folks who are from communities of color, particularly know that their needs have not been addressed, that they're treated as other. And so, when they go into a healthcare institution...if you are non-English speaking or you have a mental illness or all of the above, or are of different race, and you go into a building where no one looks like you and people treat you as other, then you're not going to trust those folks and you're not likely to come back if you're not feeling if people are not welcoming.

- Key Informant

.....  
There are young people who identify as LGBT who don't seek medical support because of the fear that they have about being discriminated against, there are not enough doctors who are culturally competent enough.

- Key Informant

.....  
Not only do the people who deliver health care need to change, but also the people who receive healthcare also need to change. This is a two-way dynamic in that the people who deliver healthcare need to think about the different origin stories of the people that they are serving medically. The people who are receiving those medical services, they need to adjust to a healthcare delivery system that also seeks to prevent illness and not only treat illness.

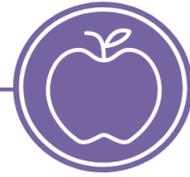
- Key Informant

.....  
There are far too many people within the healthcare system who aren't trained to treat or interact with the LGBT community.

- Focus Group Participant

## Prioritized Health Topic #3: Community Conditions (made up of Access to Healthy Food & Community Safety)

### Access to Healthy Food



- Identified as a significant health need through community feedback by **key informants**

#### Key Themes from Community Input

- General access and affordability
- Connection to economy and jobs
- Connection of healthy food access to chronic illnesses
- Increase in food insecurity during COVID-19
- Food insecurity among low-income Older Adults

### Community Safety



- Identified as a significant health need through **secondary data analysis**, and from **key informants**
- Areas of concern identified through the secondary data analysis include:
  - Death Rate due to Drug Poisoning
  - Age-Adjusted Death Rate due to Motor Vehicle Collisions
  - Age-Adjusted Death Rate due to Falls

#### Key Themes from Community Input

- Influence of using/selling drugs on community safety
- Gun violence
- Impact on mental health/stress
- Fear among transgender individuals given high prevalence of violence among LGBTQ+ people, being misgendered, feeling safe around law enforcement, etc.

#### Secondary Data

Community Conditions is a health topic that is analyzed from the categories of Prevention & Safety and Nutrition & Healthy Eating secondary data health topics. From the secondary data scoring results, indicators under the Prevention & Safety ranked 1<sup>st</sup> in the overall data scoring; while Nutrition & Healthy Eating topic ranked lower at 20<sup>th</sup> place. 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 8 below. See [Appendix B](#) (p. 153) for the full list of indicators categorized within this topic.

Table 8: Data Scoring Results for Community Conditions

SCORE	Community Conditions	Cuyahoga County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.92	People 65+ Living Alone	35.4	--	29.4	26.3			
2.42	Age-Adjusted Death Rate due to Motor Vehicle Collisions	3.9	--	2.7	2.6	--	--	
2.36	Single-Parent Households	38.2	--	26.9	25.3			
2.31	Social Associations	9.2	--	11	9.3			
2.03	Youth not in School or Working	2.4	--	1.9	1.8			
2.00	People Living Below Poverty Level	17.1	8	13.6	12.8			
1.94	Substantiated Child Abuse Rate	10	8.7	6.8	--		--	
1.92	Children Living Below Poverty Level	24.8	--	19.1	17.5			
1.92	People 65+ Living Alone (Count)	79820	--	--	--	--	--	
1.86	Linguistic Isolation	2.6	--	1.4	4.3			
1.81	Mean Travel Time to Work	24.3	--	23.7	26.9			
1.75	Median Household Income	51741	--	58116	64994			
1.75	Social and Economic Factors Ranking	72	--	--	--		--	--
1.75	Young Children Living Below Poverty Level	26.7	--	21.8	19.1			
1.67	Consumer Expenditures: Fruits and Vegetables	838.8	--	864.6	1002.1			--
1.64	Violent Crime Rate	881.3	--	--	--		--	
1.50	Consumer Expenditures: High Sugar Foods	502.1	--	519	530.2			--
1.50	WIC Certified Stores	0.1	--	--	--			--

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

One of the poorer performing indicators under Community Condition health topics are People 65+ Living Alone and Age-Adjusted Death Rate due to Motor Vehicle Collisions. People 65+ Living Alone is the percentage of people aged 65 years and over who live alone and has a value of 35.4% in Cuyahoga County, which falls in the lower 25% of the counties for both Ohio and the U.S. This indicator also shows an increasing trend over time, though it is not statistically significant. Secondly, Age-Adjusted Death Rate due to Motor Vehicle Collisions is 3.9 deaths/100,000 population in Cuyahoga County. This indicator shows an increasing trend over time. The indicator Single-Parent Households shows the percentage of children living in single-parent family households. The value for Cuyahoga County, 38.2%, falls in the lower 25% of counties for both Ohio and the U.S. And, while this indicator shows a decreasing trend over time, it is not statistically significant.

**Primary Data**

**Community Safety**

While Prevention & Safety was the highest scoring area from secondary data scoring, it was also a trending topic of concern from community feedback. In particular, the increase in gun violence and its implications for overall community safety and a feeling of wellbeing was discussed. The influence of selling and using drugs on community safety was another common trend in the discussion pertaining to community safety. The overall impact that stress related to community safety has on the mental health of the community was of concern as well.

.....  
“ I think safety is a big issue in this community. There's a lot of crime, a lot of it driven by drugs, drug use or just the sale of drugs. So, I think safety is really, really important to people.  
”  
- Key Informant  
.....

**Access to Healthy Food**

Access to Healthy Food was a trending area of concern that was frequently discussed by community members. General access to and affordability of healthy food was mentioned and community members connected these factors to the overall state of the economy and impact of job loss or jobs that did not pay living wages. They also discussed that there had been an overall increase in food insecurity during COVID-19 and that food insecurity is of particular concern for low income older adults.

Key informants in particular discussed the importance of access to healthy food in relation to prevention and management of chronic illness. The quotes below further highlight the key themes discussed in the qualitative data.

.....  
We know that these (Chronic Diseases) are diseases that are really hard to treat without access to healthy food. We also know that there are illnesses that are directly influenced by food insecurity and that food insecurity increases the risk of certain chronic illnesses.  
- Key Informant  
.....

.....  
More healthy food available to more people who need it via additional access. Additional access could mean home delivered meals for seniors. It could mean food pantries that are open in the evening and on the weekends. It could take on many forms.  
- Key Informant  
.....

# Prioritized Populations

The following section provides a detailed description of each prioritized population from this CHNA. An overview is provided for each population, followed by a table highlighting the poorest performing indicators and a description of key themes that emerged from community feedback.

## Priority Population: Older Adults

### Older Adults



- Identified as a significant health need through community feedback by **key informants**
- One of the top populations of concerns identified in **secondary data analysis**
- Areas of concern identified through the secondary data analysis include:
  - People 65+ Living Alone
  - People 65+ Living Below Poverty Level
  - Cancer: Medicare Population
  - Alzheimer's Disease or Dementia: Medicare Population
  - Age-Adjusted Death Rate due to Falls
  - Atrial Fibrillation: Medicare Population
  - Osteoporosis: Medicare Population
  - Asthma: Medicare Population

#### Key Themes from Community Input

- Mental Health impact of COVID-19 because of social isolation
- Food insecurity among the 65+ population
- Poverty
- Access to care and services
- Intersecting identities can create additional challenges (e.g. being Black and LGBTQ+, being an older adult with a disability, etc.)

### Secondary Data

Older Adults are a key population group that was analyzed from secondary data health topics. From the secondary data scoring results, Older Adults ranked 7th overall. 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. See [Appendix B](#) (p. 153) for the full list of indicators categorized within this topic.

Table 9: Data Scoring Results for Older Adults

SCORE	Older Adults	Cuyahoga County	HP2030	Ohio	U.S.	Ohio Counties	U.S. Counties	Trend
2.92	People 65+ Living Alone	35.4	--	29.4	26.3			
2.75	People 65+ Living Below Poverty Level	11.2	--	8.2	9.3			
2.31	Cancer: Medicare Population	9	--	8.4	8.4			
2.17	Alzheimer's Disease or Dementia: Medicare Population	11.4	--	10.4	10.8			
2.14	Age-Adjusted Death Rate due to Falls	11.5	--	10.8	9.8			
2.14	Atrial Fibrillation: Medicare Population	9	--	9	8.4			
2.08	Osteoporosis: Medicare Population	6.3	--	6.2	6.6			
2.03	Asthma: Medicare Population	5.2	--	4.8	5			
1.92	Chronic Kidney Disease: Medicare Population	25.2	--	25.3	24.5			
1.92	People 65+ Living Alone (Count)	79820	--	--	--	--	--	
1.92	People 65+ Living Below Poverty Level (Count)	24248	--	--	--	--	--	
1.92	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	35.4	--	36.1	33.5			
1.75	Adults 65+ who Received Recommended Preventive Services: Females	28.6	--	--	28.4			--
1.75	Depression: Medicare Population	18.5	--	20.4	18.4			
1.69	Heart Failure: Medicare Population	15.3	--	14.7	14			
1.67	Colon Cancer Screening	63.7	74.4	--	66.4			--
1.67	People 65+ with Low Access to a Grocery Store	3.4	--	--	--			--
1.58	Adults 65+ with Total Tooth Loss	15.5	--	--	13.5			--

\*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.

One of the poorer performing indicators under Older Adults health topics is People 65+ Living Alone. People 65+ Living Alone is the percentage of people aged 65 years and over who live alone and has a value of 35.4% in Cuyahoga County, which falls in the lower 25% of the counties in both the Ohio state and the nation. It also shows a trend over time with increase in the percentage of People 65+ Living Alone; however, it is not statistically significant. A few of the worse performing indicators under Older Adults topic are Cancer: Medicare Population, Age-Adjusted Death Rate due to Falls, Atrial Fibrillation: Medicare Population, Chronic Kidney Disease: Medicare Population, and a few others fall in the lower 50% of the counties in both the Ohio state and the nation, furthermore, they also show a trend over time with significant increase in the values of these indicators in Cuyahoga County.

## Primary Data

The Older Adult Population was also a key population group that was discussed in qualitative community feedback. The impact of COVID-19 on the mental health of older adults in Cuyahoga County was specifically of concern because this group is already socially isolated and this was only made worse during the pandemic. Mental health and challenges accessing mental health services were mentioned by older adults who identify as LGBTQ+ who participated as focus group participants. They also mentioned that while resources such as the suicide hotline are available, loneliness and depression can be silent killers. A potential solution to overcome social isolation would be to create more supportive and inclusive environments where individuals feel comfortable and safe congregating together.

The overall impact of poverty among older adults was another key area of concern for the older adult community, especially the ability to pay for their basic living needs. Older adult focus group participants mentioned factors such as caps on social security coverage or income eligibility limits as economic barriers to accessing the care they need.

Other social and economic determinants of health were discussed as well. Food insecurity among those 65 and older was specifically discussed as well as housing insecurity. Community members discussed housing affordability and pointed out that some neighborhoods are becoming too expensive to be affordable options. Long waitlists for housing were also mentioned as a specific barrier for stable housing.

Transportation was another area discussed as a barrier to care for older adults. Safety concerns were mentioned as an issue when using the regional transit authority (RTA). Participants also advocated for improved crosswalks and more accessible and designating parking on city streets.

Finally, for those community organizations offering specific services that cater to the older adult population, it was recommended that they work to improve their outreach in general and to incorporate more diversity, equity, and inclusion (DEI) considerations in their planning and programming.

## Prioritized Population: Maternal, Fetal, & Infant Health

# Maternal, Fetal, & Infant Health



- Identified as a significant health need through community feedback by **key informants**
- One of the top health needs identified in **secondary data analysis**
- Areas of concern identified through the secondary data analysis include:
  - Babies with Low Birth Weight
  - Babies with Very Low Birth Weight
  - Child Food Insecurity Rate
  - Projected Child Food Insecurity Rate

### Key Themes from Community Input

- Disparities in Infant and Maternal Mortality
- Sleep related infant deaths
- Increase access to prenatal care; address disparities
- Continued support/funding for alternative care models like Community Health Workers and/or Doulas

## Secondary Data

Maternal, Fetal, & Infant Health is a health topic that is analyzed from secondary data health topics. From the secondary data scoring results, Maternal, Fetal, & Infant Health had the 10th data score of all topic areas. 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. See [Appendix B](#) (p. 153) for the full list of indicators categorized within this topic.

**Table 10: Data Scoring Results for Maternal, Fetal, & Infant Health**

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	--		--	
1.50	WIC Certified Stores	0.1	--	--	--			--

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

One of the poorer performing indicators under Maternal, Fetal, & Infant Health, is Babies with Low Birth Weight which shows the percentage of births in which the newborn weighed less than 2,500 grams and is at 10.8% in Cuyahoga County, which falls in the lower 25% of the counties in the state of Ohio. It also shows a trend over time with a decrease in the percentage of Babies with Low Birth Weight but is not statistically significant. Secondly, Babies with Very Low Birth Weight, Infant Mortality Rate, and Preterm Births in Cuyahoga County, all show a trend over time with decrease in values but is statistically not significant in Cuyahoga County.

### Primary Data

Maternal, Fetal, and Infant Health was another population of concern trending from qualitative discussions during this CHNA. The disparities in health outcomes, in particular disparities in infant and maternal mortality was discussed. As is the case across the United States, infant and maternal mortality disproportionately impacts Black/African American mothers and babies. A specific factor contributing to infant deaths that was discussed by community members was sleep related infant deaths. Respondents argued that more needs to be done in relation to outreach and education to prevent these deaths.

Areas of opportunity to address Maternal, Fetal, and Infant Health mentioned by community respondents included increasing access to prenatal care and addressing disparities. They argued for continued support and additional funding for alternative care models such as Doulas or Community Health Workers to improve quality and increase access to care for moms and babies.

.....

“ Don't know what to do sometimes about infant mortality...most are tied to unsafe sleep practices. I see discussions about bed sharing and bedding has occurred, but data are still disproportionately impacting the African American community. ”

- Key Informant

.....

# Overarching Focal Areas

Structural and Institutional Racism and Trust were additional focal areas highlighted in community discussions. An overview is provided below, followed by a description of key themes that emerged from qualitative feedback.

## Additional Overarching Focal Areas: Eliminating Structural & Institutional Racism and Enhancing Trust

### Structural and Institutional Racism and Trust



- Identified as a significant health need through community feedback by **key informants**

#### Key Themes from Community Input



- Long-term health impacts of racism
- Importance of policy to addressing racism
- Racism as a root cause of many of the Social and Economic Determinants of Health
- Addressing issues of trust

#### Primary Data

Eliminating Structural and Institutional Racism and Enhancing Trust and Trustworthiness across sectors, people, and communities will continue to be two overarching focal areas for work in Cuyahoga County based on findings from this 2022 CHNA. These were identified as important overall focal areas during the 2019 CHNA, as well. In the 2019 report<sup>24</sup>, it was mentioned that “Both racial and economic segregation stemming from historical policies, such as redlining, continue to create differences in opportunity for residents of color in Cuyahoga County that has directly resulted in poorer health outcomes and that daily stress, particularly among the African American population, were specifically mentioned by social service agencies and many interviewees as impacting health.” The report went on to explain that “this historical context also heavily impacts poverty, which leads to health inequities related to housing, including lead poisoning and respiratory illnesses affected by indoor air quality.”

<sup>24</sup> 2019 Cuyahoga County Community Health Needs Assessment Adopted by Southwest General Health Center on September 25, 2019; Adopted by St. Vincent Charity Medical Center on October 2, 2019; and Adopted by University Hospitals on September 24, 2019. Access from <https://hipcuyahoga.org/2019cha/>

Additionally, a key finding from the 2019 State Health Assessment<sup>25</sup> was that “historical and contemporary injustices compound over a lifetime, leading to higher rates of infant deaths, blood pressure, late-stage cancer diagnoses, and shorter lives for some groups, particularly Black/African-American Ohioans.”

Similarly, community members who participated as key informants or in focus groups discussed the long-term health impacts of racism and recognized racism as a root cause of many of the social and economic determinants of health. They also recognized the important role policy change has in addressing racism.

As discussed earlier in relation to Accessible and Affordable Healthcare, issues of trust within the community create barriers to care, as community members do not feel heard or seen by their care providers. Focus Group participants shared that “people need to be heard and recognized,” and that having their lived experience validated and “being seen, being respected, and being heard” are “definitive approach[es] to justice.” They said that it is important that providers know and understand what their patients are going through.

LGBTQ+ focus group participants also mentioned the importance of understanding and considering the “intersecting identities” of individuals. For example, dealing with structural racism and being transgender can result in an individual’s base level of stress being very high to begin with. The quotes below further highlight key themes discussed in the qualitative data.

.....  
Institutionalized racism in one area of racism  
that supports and reinforces other forms of racism. It  
feels impenetrable. You lose hope. But you have to keep  
fighting.  
- Focus Group Participant  
.....

.....  
Structural racism is a core issue that needs to be  
addressed. It creates and sustains conditions of  
suffering that people live with each day and contributes  
to and sustains some of the issues like lead exposure,  
pollution in residential neighborhoods, and gun  
violence.  
- Key Informant  
.....

---

<sup>25</sup> 2019 Ohio State Health Assessment (SHA): Summary Report. Ohio Department of Health and Health Policy Institute of Ohio. Accessed from [https://www.healthpolicyohio.org/wpContent/uploads/2019/05/2019SHA\\_DRAFT\\_05312019.pdf](https://www.healthpolicyohio.org/wpContent/uploads/2019/05/2019SHA_DRAFT_05312019.pdf)

.....

The root cause of racism is white supremacy. Also, structural inequities...the way our systems are built.



Racism is not like the racist who uses terrible language running down the street. It's the structural systems that are set up to keep people down.



- Key Informant

.....

.....

We know there is a disparity with respect to sentencing and bond/bail program, these issues tend to hurt individuals who don't have means or resources even among those who have committed the same offense.



- Key Informant

.....

.....

Exposure to adversity and chronic stress for community members are important issues to consider because they contribute to and exacerbate health issues from conception through to end of life and undermine our ability as individuals to make healthy choices for ourselves.



- Key Informant

.....

.....

Policy is important to think and talk about, and policy is in direct alignment with direct services and how we provide services; these two have to work together; look at the policy makers and who are making those decisions and what that means to communities experiencing the impact of racism.



- Key Informant

.....

.....

Leadership within organizations need to be more diverse in order for those organizations to be more diverse.



- Key Informant

.....

# Non-Prioritized Significant Health Needs

The following significant health needs, presented in alphabetical order, emerged from a review of the primary and secondary data. While the Cuyahoga County CHNA Steering Committee organizations will not directly focus on these topics in their Community Health Improvement Plan, additional opportunities will be identified to grow existing work and to support programming in new areas as they arise.

Key themes from community input are included where relevant for each non-prioritized health need along with warning indicators.

## Non-Prioritized Health Need #1: Economic Concerns

### Economic Concerns



- Identified as a significant health need through community feedback by **key informants**
- One of the top quality of life areas identified in **secondary data analysis**
- Areas of concern identified through the secondary data analysis include:
  - People 65+ Living Below Poverty Level
  - Unemployed Workers in Civilian Labor Force
  - Persons with Disability Living in Poverty (5-year)
  - Homeownership
  - Child Food Insecurity Rate
  - Income Inequality
  - Projected Child Food Insecurity Rate
  - Youth not in School or Working
  - Adults who Feel Overwhelmed by Financial Burdens
  - Food Insecurity Rate
  - Households that are Below the Federal Poverty Level
  - People living below the poverty line

## Key Themes from Community Input

- Need for better and more accessible jobs
- Accessible transportation is a barrier
- Need for fair and equitable wages
- Labor shortages
- Disparities exist in income
- Economic issues/challenges have been exacerbated because of COVID-19

“

.....  
There is inequity imbedded into our economic and educational system that so greatly impact health outcomes.

- Key Informant

”

“

.....  
You know, if you don't have money to live in a safe, clean community or you don't have money for appropriate food, then that is certainly going to have an impact on your health in addition to any stress that you might feel as a result of your environment or your living conditions. And if your basic needs aren't getting met, then you have additional challenges in terms of potential trauma and that's gonna impact your health greatly.

- Key Informant

”

## Non-Prioritized Health Need #2: Education

# Education



- Identified as a significant health need through community feedback by **key informants**
- One of the top quality of life areas identified in **secondary data analysis**
- Areas of concern identified through the secondary data analysis include:
  - 4th Grade Students Proficient in Math
  - 8th Grade Students Proficient in Math

### Key Themes from Community Input

- Literacy Gaps
- Disparities in educational system
- Education challenges' impact on staffing
- COVID-19 Impact

.....

During COVID, teachers were unable to pick up on things with the students they would have been in the classroom. For example, child abuse and neglect. There was a lack of engagement and poor attendance in some areas. It was scary for schools built with the purpose of caring for and educating students.

“ ”

- Key Informant

.....

## Non-Prioritized Health Need #3: Environmental Health

# Environmental Health



- Identified as a significant health need through community feedback by **key informants**
- One of the top quality of life areas identified in **secondary data analysis**
- Areas of concern identified through the secondary data analysis include:
  - Adults with Current Asthma
  - Fast Food Restaurant Density
  - Houses Built Prior to 1950
  - Asthma: Medicare Population
  - Blood Lead Levels in Children ( $\geq 10$  micrograms per deciliter)

### Key Themes from Community Input

- Safe and affordable housing
- Pediatric lead exposure
- Disparities in both above

.....

“ Environmental toxins, especially lead, is a key health issue because it touches children so early in life and impacts them long-term and compromises the potential they come into the world with. ”

- Key Informant

.....

.....

“ It's access to fair wages, living wages, it's access to quality food, it's access to fair housing, I mean housing is one of the hardest needs that we have to meet. We have requests around housing on a very regular basis... It's really challenging for us to get people into better housing situations. ”

- Key Informant

.....

# Community Resources Available to Potentially Address Needs

The list of community resources below was identified to potentially address the needs identified through this assessment process:

## Behavioral Health

### Mental Health/Suicide

- Better Health Partnership - Pathways Community HUB
- Cuyahoga County Board of Health - Cuyahoga County Overdose Data to Action (OD2A) Initiative
- Early Ages Healthy Stages - Social Emotional Health - ACE's
- FrontLine Service
- LifeAct
- National Alliance on Mental Illness (NAMI)
- Project Lift
- Southwest General - Adult inpatient Psychiatric unit
- Southwest General - Geriatric inpatient Psychiatric unit
- Southwest General - IOP mental health services for Adolescents
- Southwest General - Partial hospitalization (PHP) and Intensive Outpatient (IOP) programming for adults with mental health disorders
- St. Vincent - Electroconvulsive therapy (ECT)
- St. Vincent - Inpatient Behavioral Health Unit (Adult and Geropsychiatry)
- St. Vincent - Psychiatric Emergency Department
- The MetroHealth System- Behavioral Health Services
- The MetroHealth System- Cleveland Heights Behavioral Health Hospital
- The MetroHealth System- Mental Health First Aid Trainers
- The MetroHealth System - SAFE (Students are Free to Express)
- UH Rainbow Babies & Children's -ROSES Program (Perinatal Depression Prevention)

### Opioid Use Disorder/Substance Use Disorder

- Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Board of Cuyahoga County
- Berea Police Department - Safe Passages Initiative
- Better Health Partnership - Pathways Community HUB
- City of Lakewood - Project SOAR (Supporting Opiate Addiction Recovery)
- City of Westlake Police & Fire Department
- Cleveland Department of Public Health - CenterPoint Treatment Program
- Cleveland Department of Public Health - Project DAWN, McCafferty Health Center
- Cleveland Suboxone Clinic
- Community Action Against Addiction
- Cuyahoga County Board of Health - Cuyahoga County Overdose Data to Action (OD2A) Initiative
- Cuyahoga County Division of Child and Family Services
- Cuyahoga County Division of Senior and Adult Services

- Cuyahoga County Health and Human Services
- Cuyahoga County Jobs and Family Services
- Cuyahoga County Opiate Task Force
- Front Steps Housing and Services
- FrontLine Services
- Greater Cleveland Drug Court
- Lakewood Elks Lodge - Drug Awareness Program
- Matt Talbot Inn
- Mental Health and Addiction Advocacy Coalition
- Moore Counseling and Meditation Services
- Mt. Sinai Healthcare Foundation
- Narcotics Anonymous
- Northeast Ohio Hospital Opioid Consortium
- Oakview Behavioral Health Center
- Oakview Facility for Resident Inpatient Services
- Police and fire departments of cities under UH medical direction
- Recovery Resources
- Signature Health
- Smart Recovery
- Southwest General - Ambulatory/Office Based Outpatient Behavioral Health Services
- Southwest General - Inpatient Medical Withdrawal Management Program (BreakThru)
- Southwest General - IOP Services for Adults Facing Addiction
- Southwest General - Safe Passages Program
- Southwest General - Speakers Program on Addiction, Opioids, and Mental Health
- St. Luke's Foundation
- St. Vincent Door to Door transportation program for outpatient Rosary Hall patients
- St. Vincent Rosary Hall/Psychiatric ED/Behavioral Health Inpatient/Research
- Stella Maris
- The Bruening Foundation
- The Centers for Families and Children
- The Cleveland Foundation
- The George Gund Foundation
- The LCADA Way
- The MetroHealth System - Office of Opioid Safety - Ascent ED Peer Support Program
- The MetroHealth System - Office of Opioid Safety - Medication Assisted Treatment Program
- The MetroHealth System - Office of Opioid Safety - Project DAWN (Deaths Avoided with Naloxone)
- The MetroHealth System - Office of Opioid Safety - Quick Response Teams
- The Woodruff Foundation
- UH Rainbow Babies & Children's Interdisciplinary Substance Exposure (RISE) Clinic
- University Hospitals Addiction Services Intensive Outpatient Program
- U.S. Attorney's Office Northern District Heroin and Opioid Task Force
- United Way of Greater Cleveland
- Westshore Enforcement Bureau

## Accessible and Affordable Healthcare

- AIDS Healthcare Foundation
- Asian Services in Action, Inc.
- Benjamin Rose Institute on Aging
- Better Health Partnership
- Case Western Reserve University
- Cleveland Clinic
- Cuyahoga County Department of Health and Human Services
- Cleveland Department of Public Health
- Cuyahoga County Board of Health
- Home Healthcare Agencies
- The MetroHealth System - Medworks
- Neighborhood Family Practice
- NEON
- Ohio Network Hub
- Pride Clinic: Primary Care provided at the LGBT Community Center of Greater Cleveland
- PolicyBridge
- Salaam Cleveland Free Clinic
- Southwest General
- St. Vincent Charity Medical Center - Health Literacy Institute
- The Center for Health Affairs
- The MetroHealth System
- United Way 211
- UniteOhio
- University Hospitals
- Visiting Nurse Association of Ohio

## Community Conditions

### Access to Healthy Food

- Asian Services in Action, Inc.
- Benjamin Rose Institute on Aging
- Bishop Cosgrove Center
- Change Inc.
- Cleveland Department of Aging
- Cleveland Department of Public Health - Food Distribution
- Communities in Schools of Ohio
- Community Partnership on Aging
- Cuyahoga County Board of Health - Creating Healthy Communities - Supermarket Access
- Cuyahoga County Board of Health - Early Ages Healthy Stages
- Cuyahoga County Board of Health - Farm to School
- Cuyahoga County Board of Health - Racial and Ethnic Approaches to Community Health
- Cuyahoga County Department of Job and Family Services
- Cleveland Public Libraries
- Faith based Community/Churches
- Greater Cleveland Food Bank

- Hunger Network of Greater Cleveland
- May Dugan Center
- NEON
- Produce Perks Midwest
- Salvation Army of Greater Cleveland
- The Centers
- The MetroHealth System - Food as Medicine Program
- The MetroHealth System - Mobile pantry (fresh produce distribution)
- University Hospitals - Care Transitions: CHW Program
- University Hospitals/Sodexo Food as Medicine Partnership
- United Way 211
- UniteOhio
- WIC Cuyahoga County

### **Community Safety**

- Applewood Centers, Inc.
- Beech Brook
- Begun Center for Violence Prevention at Case Western Reserve University
- Bellflower Center of Prevention of Child Abuse
- Boys & Girls Club of Cleveland - Cleveland Peacemakers Alliance
- Bright Beginnings of Cuyahoga County
- Carrington's Mission
- City of Bedford Police & Fire Department
- City of Richmond Heights Police & Fire Department
- Cleveland Mayor's Office on Youth Opportunity, Prevention & Intervention
- Cleveland Police Department
- Cleveland Rape Crisis Center
- Creating Healthy Communities – Youth Mentoring
- Cuyahoga County Division of Child and Family Services
- Cuyahoga County Division of Senior and Adult Services
- Cuyahoga County OVI Task Force
- Cuyahoga County Safe Kids Coalition
- Domestic Violence and Child Advocacy Center
- Educational Service Center of Northeast Ohio
- Greater Cleveland Safe Kids Coalition
- Lutheran Metropolitan Ministries, Adult Guardianship Program
- The MetroHealth System Trauma Recovery Center
- Northern Ohio Trauma Systems (NOTS) - Violence Interrupters
- Ohio Children's Trust Fund Great Lakes Region Council
- Partnership for Safer Cleveland
- The City of Cleveland
- UH Rainbow Babies & Children's Antifragility (AI) Initiative
- UH Rainbow Babies & Children's Child Advocacy & Protection Program
- University Hospitals SANE Programs (Adult & Pediatric)
- U.S. Attorney's Office - STANCE Program
- YWCA of Greater Cleveland

## Structural Racism

- Birthing Beautiful Babies
- Burton, Bell, Carr Development, Inc.
- Case Western Reserve University
- Cleveland Division of Health Equity and Social Justice
- Cleveland Neighborhood Progress
- Cuyahoga County Board of Health - Creating Health Communities Program
- Cuyahoga County Board of Health - Maternal and Child Health
- Cuyahoga County Board of Health - Racial and Ethnic Approaches to Community Health
- East End Neighborhood House
- First Year Cleveland
- Goodrich-Gannett Neighborhood Center
- Health Improvement Partnership (HIP) Cuyahoga - Eliminating Structural Racism Subcommittee
- Mt. Pleasant NOW Development Corporation
- Murtis Taylor Multi-Service Center
- Neighborhood Connections, Inc.
- Neighborhood Leadership Institute
- Northeast Ohio Alliance for Hope (NOAH)
- PolicyBridge
- Racism as a Public Health Crisis (RAPHC) Cleveland Coalition
- The Friendly Inn Settlement
- United Way of Greater Cleveland
- University Hospitals
- University Settlement
- West Side Community House
- YWCA Greater Cleveland

## Trust

- Case Western Reserve University
- Cuyahoga County Board of Health - Creating Health Communities Program
- Cuyahoga County Board of Health – Maternal and Child Health
- Cuyahoga County Board of Health – Racial and Ethnic Approaches to Community Health
- HIP-Cuyahoga - Linking Clinical and Public Health Subcommittee
- St. Vincent Charity Medical Center - Community Outreach - health screenings/education in the community
- St. Vincent Charity Medical Center - Health Literacy Institute
- The Center for Health Affairs
- United Way of Greater Cleveland

# Conclusion

This collaborative Community Health Needs Assessment (CHNA), conducted by the Cuyahoga County CHNA Steering Committee, leveraged primary and secondary data analysis to provide a more comprehensive picture of health in Cuyahoga County, Ohio. This report helps organizations in the Cuyahoga County CHNA Steering Committee meet national and state assessment requirements. More specifically, this report helps:

- Health Departments meet PHAB reaccreditation requirements
- Hospitals meet non-profit hospital IRS requirements as part of the Patient Protection and Affordable Care Act (ACA)
- Health Departments and Non-profit Hospitals meet the Ohio mandate that all tax-exempt hospitals collaborate with their local health departments on community health needs assessments (CHNA) and community health improvement plans (CHIP)
- Ensure alignment between Cuyahoga County CHIP planning and the latest Ohio SHIP

This collaborative assessment determined ten health needs in Cuyahoga County. The prioritization process identified the top three health needs including:

- Behavioral Health (Mental Health & Drug Use/Misuse)
- Accessible and Affordable Healthcare
- Community Conditions (Access to Healthy Food & Community Safety)

In addition to these three prioritized health need categories, two prioritized populations were identified including Maternal, Fetal, and Infant Health as well as the Older Adult population. Finally, Eliminating Structural Racism and Enhancing Trust and Trustworthiness Across Sectors, People, and Communities will continue to be two overarching focal areas for work in Cuyahoga County.

## 2022 Cuyahoga County CHNA Alignment

The final prioritized health needs from this 2022 Cuyahoga County CHNA are in alignment with some of the top priorities and factors influencing health outcomes from the 2019 Ohio SHA/SHIP. They are also in alignment with a subset of 2019 Cuyahoga County CHNA priority areas. This icon indicates areas of alignment  .

2019 Ohio SHA/SHIP	2022 Cuyahoga County CHNA
<p>Top Health Priorities:</p> <ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> • Mental Health &amp; Addiction</li> <li><input checked="" type="checkbox"/> • Chronic Disease</li> <li><input checked="" type="checkbox"/> • Maternal and Infant Health</li> </ul> <p>Top Priority Factors Influencing Health Outcomes:</p> <ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> • Community Conditions</li> <li><input checked="" type="checkbox"/> • Health Behaviors</li> <li><input checked="" type="checkbox"/> • Access to Care</li> </ul>	<p>Prioritized Health Needs:</p> <ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> • Behavioral Health (Mental Health &amp; Drug Use/Misuse)</li> <li><input checked="" type="checkbox"/> • Accessible and Affordable Healthcare</li> <li><input checked="" type="checkbox"/> • Community Conditions (Access to Healthy Food &amp; Community Safety)</li> </ul> <p>Prioritized Populations</p> <ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> • Maternal, Fetal, &amp; Infant Health</li> <li>• Older Adults</li> </ul> <p>Overarching Focal Areas</p> <ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> • Structural and Institutional Racism &amp; Trust</li> </ul>

The findings in this report will be used to guide the development of a new Cuyahoga County Community Health Improvement Plan (CHIP), which will outline strategies to address identified priorities and improve the health of the community in Cuyahoga County. The CHIP will also serve to meet Non-profit Hospital partners' IRS requirements to create an Implementation Strategy (IS) for Cuyahoga County.

# Appendices Summary

The following support documents are shared as appendices:

## **A. Look Back: Progress Since Previous CHNA**

The previous collaborative Cuyahoga County CHNA was implemented in 2019. An important piece of this assessment cycle includes the ongoing review of progress made on priority health topics set forth in the preceding CHNA and Community Health Improvement Plan (CHIP). Nonprofit hospital partners have included impact evaluation reports highlighting efforts taken to address priority health issues and evaluating the impact those actions have made in the community. This look back makes it possible to better target resources and efforts during the next CHNA/CHIP.

## **B. Secondary Data Methodology and Data Scoring Tables**

A description of Cuyahoga County secondary data scoring methodology, including a list of secondary data sources used in the analysis and county-level topic and benchmark results.

## **C. Community Input Assessment Tools**

Data collection tools that were vital in capturing community feedback, including the key informant interview and focus group guides. Additional support documents provided during virtual community prioritization activities are presented here as well.

# Appendix A: Look Back-Progress Since Prior CHNA

The previous collaborative Cuyahoga County CHNA was implemented in 2019. An important piece of this assessment cycle includes the ongoing review of progress made on priority health topics set forth in the preceding CHNA and Community Health Improvement Plan (CHIP) (Figure 3). By reviewing the actions taken to address priority health issues and evaluating the impact those actions have made in the community, it is possible to better target resources and efforts during the next assessment.

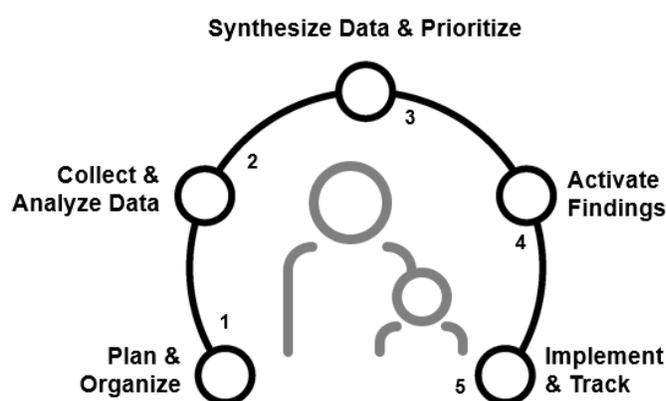
## Priority Health Needs from Preceding CHNA

Cuyahoga County's five priority health areas from the 2019 CHNA were:

- Eliminating structural racism\*
- Enhancing trust and trustworthiness across sectors, people, communities\*
- Addressing community conditions, such as reducing poverty and its effects
- Enhancing mental health and reducing substance abuse
- Reducing chronic illness and its effects

*\* Long-term, cross-cutting strategies that will be integrated into each of the other priority areas through an intentional plan to address these fundamental contributors to the health of both individuals and populations within Cuyahoga County.*

Figure 3. The CHNA Cycle



## Evaluation of Impact

### Evaluation of Hospital Community Health Improvement Efforts

An evaluation of the impact of the strategies Southwest General Health Center, St. Vincent Charity and the seven University Hospitals facilities that are located within Cuyahoga County have are presented in this section.



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## Evaluation of Impact

## Southwest General Health Center

Southwest General Health Center is an award-winning, 363-bed, non-profit acute care facility located in Middleburg Heights, Ohio. The hospital was founded in 1920 by citizens of the surrounding communities. Today, the hospital serves cities in southwestern Cuyahoga, eastern Lorain and northern Medina counties. Southwest General has a rich history of community partnership and a deep commitment to providing a healthy future for the communities it serves through its continuum of care for patients. A unique partnering agreement with University Hospitals helps Southwest General continue to provide innovative patient care, including enhanced clinical services and program development. Southwest General offers comprehensive medical and surgical care, including a Level III trauma center and a newly accredited Level II neonatal and maternity care center. The Health Center prides itself on the extensive behavioral health care provided to the community along with home health, hospice and cancer care services. Southwest General has been named one of the “Top Workplaces” by The Plain Dealer for nine consecutive years and has been recognized as one of the great workplaces for top talent in Northeast Ohio, having earned the NorthCoast 99 Award from the Employers Resource Council for fourteen years.

In 2019, Southwest General Health Center collaborated with the Center for Health Affairs, area health care institutions, academia, public health and community organizations and citizens in our surrounding communities to develop our Community Needs Assessment Plan. The top needs were identified through primary and secondary data collection and analysis. The identified needs aligned with those of the State Health Assessment (SHA) and the State Health Improvement Plan (SHIP). Therefore, in September 2019, the top priority needs identified in the Cuyahoga County Community Health Needs Assessment (CHNA) were adopted by Southwest General Health Center, including:

1. reducing chronic disease and its effects
2. addressing community conditions
3. enhancing mental health and reducing substance abuse
4. eliminating structural racism
5. enhancing trust

From these top priority needs, the Health Center chose to work on three of the identified priorities: reducing chronic disease and its effects; addressing community conditions; and enhancing mental health and reducing substance abuse. In addition to working on these priorities, Southwest General Health Center conducted a [supplementary](#) survey within its local community and the results coincided with the top priorities identified above. The Health Center chose to work on Chronic Disease Management and Prevention; Community Conditions: Poverty, Violence, Safety; and Mental Health and Addiction.

### Chronic Disease Management and Prevention: Seidman Cancer Center

Southwest General continued its initiative for early detection of colorectal cancer through improved access to colonoscopies. The hospital allows direct scheduling of a screening colonoscopy without a physician’s referral; reminders about the need for a screening are sent to patients as they turn 50 years old; and patient education on the need for screening is shared through community events the hospital participates in annually.

Cancer screenings performed past three years:

	2019	2020	2021
Screening Colon Cancer	276	306	309
Screening Lung Cancer	398	440	641
Screening Mammogram	10,797	9,993	10,794

The hospital created numerous educational print publications and other collateral material for distribution in the hospital and in the community by hospital staff at community-based events. At the same time, Southwest General maintained a consistent social media presence to promote disease management services available in the community and to share general health and wellness information. Additionally, the hospital’s website outlines all disease management services available to community members from Southwest General as well as services offered by other community organizations.

Medication costs are frequently an issue for patients, particularly the cost of medications used in cancer treatment. Southwest General provides a Medication Assistance Program for patients receiving treatment in its cancer center. Through the program, a Pharmacy employee works with pharmaceutical companies and disease-specific foundations to help patients with the cost of their medications. This assistance may include receiving medication at no cost or receiving co-pay assistance. Below is the data for years 2020 and 2021:

<b>Medication Assistance Program Data</b>	<b>YTD 2021</b>	<b>YTD 2020</b>
Product replacement	\$337,593.25	\$641,734.54
Copay card assist	\$137,869.30	\$105,327.94
Foundation assist (used to help cover ded/oop)	\$91,325.99	\$93,870.50
Total hospital assist	\$566,788.54	\$840,932.98
Free meds, copay oral med/misc. assist premium assist	\$3,561,379.73	\$2,546,483.27
Total assistance	\$4,128,168.27	\$3,387,416.25

The cancer center employs oncology nurse navigators to assist with symptom management, new patient navigation and ongoing coordination of care, especially for patients experiencing surveillance or recurrence of their cancer. Chemotherapy education and side-effect management are a focus of the ongoing patient education provided by this group of specialized nurses.

In 2021, the cancer center added a new patient navigator who tracks referrals and arranges first-time appointments with an appropriate level provider. Based on this program improvement, the turnaround time from referral to first appointment was eight calendar days for patients with a documented malignancy.

The cancer center also developed a department-specific certified nurse practitioner (CNP) who is available for chemotherapy infusion reactions and side-effect and symptom management for all chemotherapy patients. An important initiative for the CNP is to address and resolve most chemotherapy side effects prior to referring the patients to the emergency department.

In 2020 and 2021, a dedicated breast cancer screening event occurred in collaboration with the breast center and Seidman Cancer Center at Southwest General. The event screened 50 women of various ages. The goal of the screening event is to increase knowledge, shift behaviors to increase early detection for cancer, and increase access to care.

## High Cancer Mortality Rates

Located at UH Cleveland Medical Center, one hallmark of UH Seidman Cancer Centers and Southwest Seidman Cancer Center, an improvement plan was a cross-functional examination of the barriers to preventive care and treatment among community members and its cancer patients. Provider team members examined how they provided care “through the eyes of the patients” and determined barriers to access and optimal patient outcomes. Their strategies and actions are outlined below:

It was determined in 2020 that certain geographic areas within the City of Cleveland, and the surrounding service areas are 44107 Berea, 44028 Columbia Station, 44130 Middleburg Heights, 44133 North Royalton, 44136 Strongsville, 44138 Olmsted Falls, 44142 Brook Park, 44149 Strongsville, 44256 Medina did not have adequate transportation. These areas are all in our primary service areas. Southwest Seidman Cancer worked with the community van program is this SWG’s to reach out to border communities to provide access and transportation for some of its cancer patients.

UH Seidman Cancer Center teams at Southwest General Health Center determined some patients declined care at a tertiary center, resulting in some patients with high-risk or rare cancers chose to continue receiving treatment within their local community. The affiliation with the academic University Hospital’s cancer program and Southwest Seidman Cancer Center allows expert care closer to home. Seidman Cancer Center at Southwest collaborates with the National Cancer Institute (NCI)- which designated UH Seidman Cancer Center at Southwest a university setting which facilitates the focuses on patient education and screening events.

Having information centralized within the EMR also allowed a holistic view of patients’ various needs. Interoperability enhancement and access to outside records became a reality for the specialty. The investment in an integrated EMR system, including electronic complex chemotherapy orders, allowed the hospital and Cancer Center to maintain a safe reliable format for the distribution for high-risk medication administration.

UH Seidman Cancer Center at Southwest General Health Center changed tactics in combating cigarette smoking among cancer patients. Now, all cancer patients are screened for smoking, and within the continuum of care and treatment. The patients are presented, multiple times, with the smoking cessation program and have the option to participate. The goal is to inject smoking cessation interventions when they can be most effective.

## **Survivorship Standard and Survivor Team**

The Cancer Committee at Southwest General Health Center, oversees the development and implementation of several quality standards, one being a survivorship program directed at meeting the needs of cancer patients treated with curative intent during the continuum of care throughout their life. The multidisciplinary team is comprised of a physician, advanced practice provider, nurse, social worker, nutritionist, physical therapist and any other allied health professionals involved in the interest of the cancer survivor. Programs such as cognitive behavioral therapy for insomnia or “chemo brain,” lymphedema, hyperbaric oxygen therapy, fitness programs, speech and occupational therapies are a few of the necessary services to complement and complete care of the cancer survivor. Services are on site or referred out to specialists in the local area.

## **Summary of Activity for 2021 Survivorship Program**

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### **Supportive Care**

For cancer survivors participating in support groups (i.e., The Gathering Place, American Cancer Society), 14% reported benefit from the support groups. The other survivors voiced adequate support from prior knowledge of their treatment journey. Facilities offering support groups were limited due to COVID restrictions during this time, and many patients took advantage of virtual options offered; however, these options are not reportable or tracked.

Of all the supportive options, nutrition registered the highest percentage with 85% participation with the registered dietitian nutritionist, licensed dietitian (RDN, LD) The psychosocial offering for survivors with the new social worker was successfully initiated the second half of 2021, and participation values are not available.

### **Activity Programs/Services**

Rehab Services: Physical Therapy, Lymphedema Services with 16 referrals (100% of patients with full axillary dissection).

Fitness Programs: Fitness is Power, YMCA, local recreation center, Silver Sneakers with 100% being encouraged and provided with referral information. Four participated in Fitness is Power, a dedicated six-week program specialized for breast cancer survivors and sponsored by Lifeworks at Southwest General.

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### **2021 Survivorship Program Summary:**

The Survivorship Program team has diligently worked to implement improved processes to ensure that the cancer patient’s physical and mental well-being is maintained from initial diagnosis, through treatment and post treatment. The on-and-off-again Covid-19 restrictions have had some effect on referrals, from both the Cancer Center and/or patient request.

### **Chronic Disease Management and Prevention: Cardiovascular Service Line**

The cardiovascular service line focused on reducing chronic illness and its effects on our community’s population and enhancing the trust and trustworthiness across sectors, people and communities. Multiple health screenings were conducted, including Healthy Heart for Him and Her, Gray Matters, Stroke Prevention and

Circulation Circuit. Chronic Care Clinics, included those for Pulmonary Hypertension, Heart Failure, COPD, Asthma and Smoking Cessation. Our Heart Failure Program is an in-depth program for heart failure patients where we work closely with patients to help them understand how to manage and live with their condition. LifeWorks of Southwest General is a health and fitness center owned by Southwest General Health Center where our patients receive cardiac and pulmonary rehab. Our cardiac and pulmonary rehabilitation programs are designed to help the patients and families make the necessary lifestyle changes for heart healthy and an active, fulfilling life. Southwest General has a stroke prevention program, including atrial septal defect closure devices, atrial fibrillation ablations, and carotid artery stenting and left atrial appendage devices. Our diabetes management program reaches out to individuals who are newly diagnosed with diabetes and those who have uncontrolled diabetes to help educate and re-educate on diet, exercise and lifestyle changes, signs and symptoms of hyperglycemia, hypoglycemia, and when to call 911.

Southwest General Health Center began a program specifically to address the continuous need of the growing population of patients diagnosed with heart failure. We began daily monitoring weight, blood pressure, and oxygen concentration saturation of the patients. Nurses monitor and call patients who need extra support on a daily basis regarding diet, exercise, and medication management.

Goals: Promote a healthy lifestyle behaviors including exercise, nutrition and stress management. Increase the understanding of the warning signs and high-risk behaviors that contribute to an increase in chronic disease. Reduce the incidences of cardiovascular, pulmonary, renal disease as well as stroke through early detection and prevention.

Objectives: Expand chronic care management and transitional care management services to patients under independent providers who utilizes Southwest as their healthcare facility. Provide appointments at the Chronic Care Clinic for those who do not have a primary care physician. Offer chronic disease maintenance and stabilization through the centralized Chronic Care Clinic and educational offerings.

2019 Chronic Disease Education Programs, Events & Activities	# Attended
Cardiovascular health education: Physician talks, Know Your Numbers, A Fib, CHF, Women and heart disease	24
Education r/t importance of regular exercise	15
Stroke awareness and prevention education	
Nutrition education: heart healthy eating, cooking for one, cooking demos, choosing healthy eating, reading food labels	20
Diabetes education	23
Osteoporosis awareness and prevention education	124
Arthritis education: physician talks, importance of exercise, pain management	419
Exercise is medicine fair	350
Relay for Life	200
Cancer prevention fair	75

<b>2020 Chronic Disease Education Programs, Events &amp; Activities</b>	
Cardiovascular health education: Physician talks, Know Your Numbers, A Fib, CHF, women and heart disease	140
Education r/t importance of regular exercise	60
Stroke awareness and prevention education	90
Nutrition education: heart healthy eating, cooking for one, cooking demos, choosing healthy eating, reading food labels	45
Osteoporosis awareness and prevention education	67
Arthritis education: physician talks, importance of exercise, pain management	80
<b>2021 Chronic Disease Education Programs, Events &amp; Activities</b>	
PAH remote education support group	4
Diabetic signs /symptoms local community organization	50

**Addressing Community Conditions**

Southwest General Health Center is required to provide emergent medically necessary health care without charge to people who cannot afford to pay for care. The Health Center understands the financial burden unplanned medical expenses can place on an individual, family and household. Southwest General offers options to provide patients with alternatives if funds are not available to pay the patient’s balance in full. These options include:

1. A monthly installment program
2. Flat-rate discounts for maternity services and Baby Imprints
3. Financial assistance for insured individuals with family income up to 250% of the Federal Poverty Guideline.

Southwest General provides a Community Nurse Program where community health screenings and education programs in convenient neighborhood locations, such as recreation and senior centers, libraries and local meeting places.

The Health Center provides free van transportation for residents in Southwest General’s taxing district who are unable to provide their own transportation to doctor appointments, tests and other clinical services at Southwest General.

During the initial phases of COVID, our Health Connection nurses contacted more than three thousand patients after they left the emergency room or the hospital to see how they were doing and if they needed any further assistance. The Health center also provided patients diagnosed with COVID free pulse oximeters to monitor their oxygen concentration, with education on signs and symptoms of respiratory distress and a number to call if the pulse ox was below 92%.

The Health Center has a Medication Disposal Program to help residents in the area safely dispose of unused medications.

Southwest General provided a school nurse program for the Berea City School District. The nurses provided basic first aid, medication assistance, control of communicable diseases and state-mandated health screenings.

Goals: Improve the quality of life for those individuals who are in the surrounding communities of Southwest General Health Center and expand access to basic health screening programs to underserved areas.

Objective: Provide community education focused on resources and programs that assist with poverty, violence and safety concerns

<b>2019 Safety Program Events &amp; Activities</b>	<b># Attended</b>
Balance education	86
Stop the Bleed education	689
Matter of Balance six-week seminars	120
Fall prevention community talks	182
Movement classes to improve coordination and balance: line dancing, tai chi, yoga	763
Medication safety education	190
Health and safety fairs	2225
<b>2020 Safety Program Events &amp; Activities</b>	
Balance education	55
Fall prevention community talks	50
Movement classes to improve coordination and balance: line dancing, tai chi, yoga	185
Medication safety education	20
Health and safety fair	300
<b>2021 Safety Program Events &amp; Activities</b>	Unable to do COVID

<b>Screenings</b>	<b>2019</b>	<b>2020</b>	<b>2021</b>
BP	6770	1281	none
Body fat	113		
CHO	6	15	
Glucose	491	111	
BMI	79		
Bone density	76	37	
Hearing	42	16	
Skin cancer	23		
Vision	52		
Memory	48		
Pulse ox	50		
Depression	56		

## Mental Health and Addiction: Behavioral Health

Our health care professionals are trained and certified to deal with behavioral health issues that include addiction, mental health disorders and struggles associated with aging. Our Oakview Behavioral Health Services focus on successful outcomes and the development of self-awareness, self-acceptance and personal responsibility. We provide assessment services, addictions services and mental health services. Additionally, we offer a Geriatric Behavioral Health Unit, which is located on the Main Campus in Middleburg Heights, inside Southwest General Health Center. All services are provided by certified health care professional who are trained to address the mental and physical challenges of behavioral disorders. Our team is multidisciplinary and is committed to guiding each and every patient to reach their full potential to attain and maintain recovery.

Southwest General Health Center is one of the very few health care centers in Cuyahoga County that provides a comprehensive inpatient and outpatient service for both mental health and or substance abuse issues. Mental health and addiction recovery services have been offered at the Health Center since the mid-1980's, and today has the following specialty areas on campus:

- a) Adult inpatient psychiatric unit
- b) Geriatric inpatient psychiatric unit
- c) Partial hospitalization (PHP) & intensive outpatient (IOP) programing for adult with mental
- d) health disorders
- e) Inpatient assessment team in the emergency department
- f) IOP mental health services for adolescents
- g) IOP services for adult facing the disease of addiction
- h) inpatient medical withdrawal management program (BreakThru®)
- i) Ambulatory outpatient behavioral health services

Goals: Improve the quality of life for those individuals who are in the surrounding communities. Decrease the use of opioids in the Health Center jurisdiction and improve continuity of care and access to mental health services.

Objective: Provide education and support to the communities around the Health Center, demonstrating a need for increased access to mental health services ad continuity of care.

Southwest community nurses work closely with area recreation centers, senior centers, libraries, schools, universities, mall and extended care facilities to provide meaningful programming to meet the CHNA priorities.

<b>2019 Mental Health Program Events &amp; Activities</b>	<b>Number Attended</b>
Depression screenings	56
Mental health education: Coping with life changes, Keys to Happiness, maintaining healthy relationships, boundaries	554
Heath fair education re: mental health awareness	689
Addiction education	24
Mental health strategies for coping with stress, anxiety, depression	123
<b>2020 Mental Health Program Events &amp; Activities</b>	

Mental health education: Coping with life changes, Keys to Happiness, maintaining healthy relationships, boundaries	45
Addiction education	100
Mental health strategies for coping with stress, anxiety, depression	50
<b>2021 Mental Health Program Events &amp; Activities</b>	Unable do to COVID

<b>Oakview Behavioral Health 2019 Events &amp; Activities</b>	<b>Number Attending</b>
Present to Berea Municipal Court probation officers	15
Host networking event with Westside Healthcare Organization	75
Host & attend monthly ElderCare Professionals of Ohio networking	75
Present to Cuyahoga County Division of Family Services	25
Attend "We Do Recover" event at Baldwin Wallace University	50
Attend Safety Fair event at Middleburg Heights Recreation Center	150
Attend Cuyahoga County Opiate Task Force Meeting (every other month)	80
Member of the Brunswick Family Assistance Coalition Team (FACT)	20
Present CEU Program for Northern Ohio Chapter of the Employee Assistance Professionals Association (NEOCEAPA)	50
Provide a resource table at Baldwin Wallace University school event	75
Sponsor the Community Substance Abuse Summit at Baldwin Wallace	25
Host Senior Resource Fair at Southwest General	200
Present to counselors, teachers and staff at Berea-Midpark High School	45
Present to Baldwin Wallace Nursing students	40
Present to University Hospitals Employee Assistance Program staff	10
Attend "Greater Than Heroin" lunch & learn quarterly meetings	100
Attend Strongsville Family Health Fair	250
Attend ADAHMS Board Career Fair	100
Attend Mental Health Awareness event at Berea-Midpark High School	35
Host and attend Safe Passages/CareSource information meeting	25
Sponsor CEU event for area long-term care facilities	75
Sponsor and attend NAMI Walks events	200
Attend Employee Health Fair at NASA	100
Present to Younger Parents Education Night at St. Ambrose Church	20
Attend Family Health Fair in North Royalton	250
Present to Stephen Ministry group at St. Ambrose Church	15
Attend "Road to Recovery" health fair	75
Provide "first-aid" training on Mental Health and Addictions at St. Ambrose Church	50
Present at Brunswick Schools Teacher In-service Day	75

<b>Oakview Behavioral Health 2020 Events &amp; Activities</b>	<b>Number Attending</b>
Present to NICHE group	45
Host and attend monthly ElderCare Professionals of Ohio networking	75
Attend Westside Healthcare Organization events	75
Attend community Health Fair in Middleburg Hts.	150
Attend Cuyahoga County Opiate Task Force meetings (every other month)	80
Host meet and greet for area assisted living facility key staff	50
Present at Columbia School District School Board meeting	20
Present at Opioid Panel Discussion at Baldwin Wallace University	75
Host Senior Resource Health Fair event for employees and community	200
Sponsor and attend NAMI Walks events	150
Host drive-thru food drive to support area local food banks	100
Present to cardiac rehab patients	25
Present via Zoom to staff at Recovery Village	25
Attend via Zoom "Wellness Wednesday" monthly events	30
Sponsor and attend via Zoom annual CEU event for local long-term care facilities	50

<b>Oakview Behavioral Health 2021 Events &amp; Activities</b>	<b>Number Attending</b>
Attend monthly network meetings for local substance use providers	45
Host and attend monthly ElderCare Professionals of Ohio networking	75
Attend Westside Healthcare Organization events	75
Attend community Health Fair in Middleburg Heights	150
Attend Cuyahoga County Opiate Task Force meetings (every other month)	80
Attend ADAMHS Board focus group for Collaborative Community Awareness Campaign	25
Host multiple Mental Health Awareness events at the hospital and in the community	200
Sponsor and attend NAMI Walks events	150
Attend via Zoom "Redefining Normal: Supporting Wellness Through Covid Transitions"	15
Present at Southwest Community Health Foundation Corporate Committee meeting	20
Attend North Royalton Family Health Fair	200
Host Dedication and Ribbon-Cutting event for Oakview Brassell Pavilion	100
Collaborate with area agency for Narcan training and distribution for patients in Southwest General Substance Use Outpatient Program	150

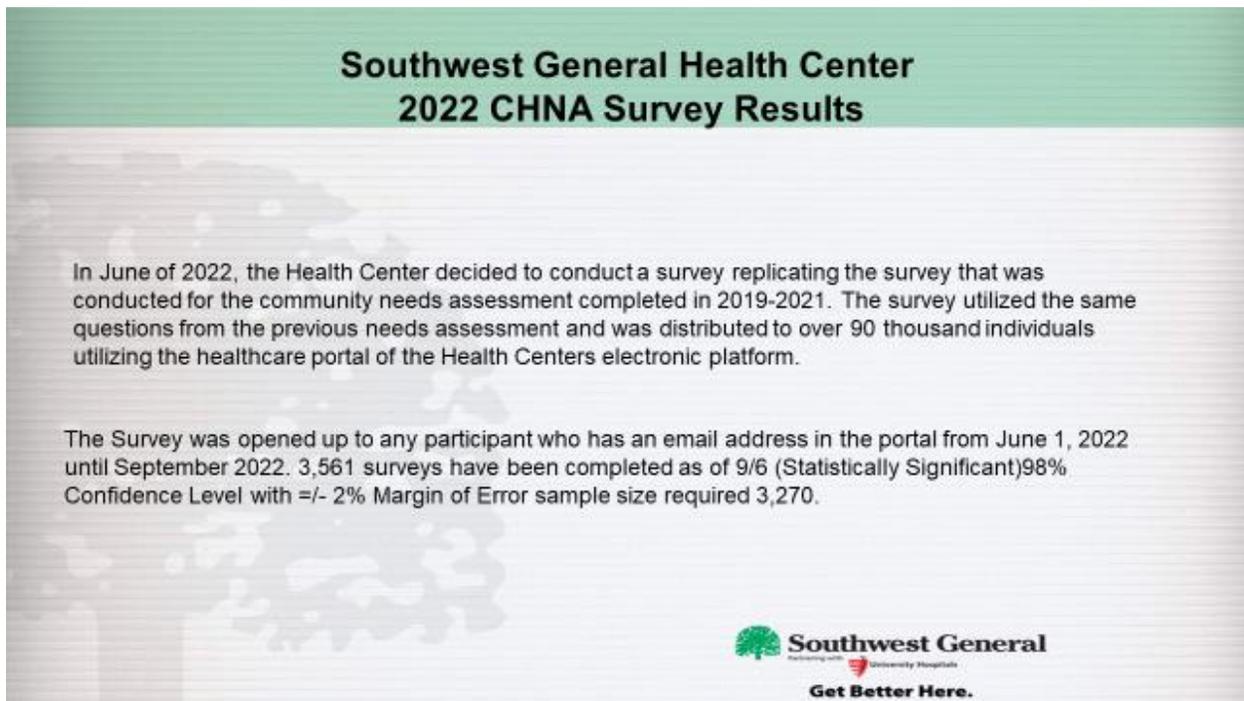
In response to the COVID-19 pandemic, in the early stages of the pandemic, Southwest General formed a multidisciplinary task force of health care providers, entitled Strike Force. These providers went to local skilled nursing facilities and helped to evaluate and educate their leadership team on best practices regarding safety with protective equipment, donning and doffing, isolation techniques, medication, ideas on staffing and effective COVID testing of the residents and staff.

The leadership team of the health center decided to meet the needs of the community during the pandemic by offering drive through COVID testing at the health center and provided vaccines at the Middleburg Heights Recreation Center. Southwest General Health Center provided 12,000 vaccines to the area residents and 3,000 vaccines to the hospital employees.

As a result of the COVID pandemic interviews were conducted with the Berea school nurses. The nurses shared the pandemic had a huge impact on the mental health of the students and the families. The isolation the students felt was palpable. The students struggled in getting their assignments completed, attending class remotely was difficult for both the students and the instructors. The fear of the unknown was overwhelming for all involved. The lack of socialization and group activities for the students left them with a feeling of longing and separation from peers. They lost the ability to connect during this time.

The physicians at Southwest General Health Center were also interviewed regarding trends they were experiencing in their practices with their patients. They saw an increase in depression, weight gain, fear, apathy. All around an increase in mental health issues which resulted in an increase in the manifestation of physical ailments. Loneliness, feelings of isolation were and continue to be very prevalent. The inability to get to appointments due to lack of transportation continues to be a pervasive issue.

## **Southwest General Health Center Supplement**



**Southwest General Health Center  
2022 CHNA Survey Results**

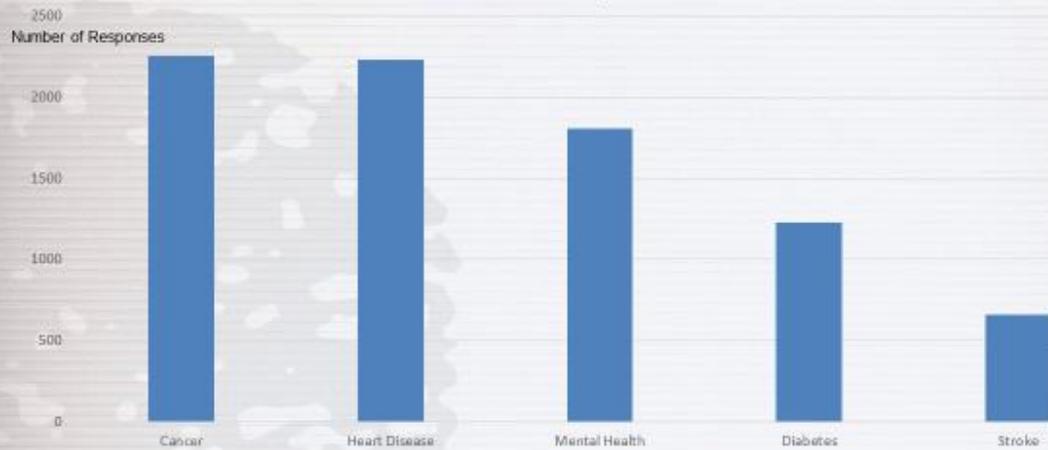
In June of 2022, the Health Center decided to conduct a survey replicating the survey that was conducted for the community needs assessment completed in 2019-2021. The survey utilized the same questions from the previous needs assessment and was distributed to over 90 thousand individuals utilizing the healthcare portal of the Health Centers electronic platform.

The Survey was opened up to any participant who has an email address in the portal from June 1, 2022 until September 2022. 3,561 surveys have been completed as of 9/6 (Statistically Significant)98% Confidence Level with +/- 2% Margin of Error sample size required 3,270.

 **Southwest General**  
Partnering with University Hospitals  
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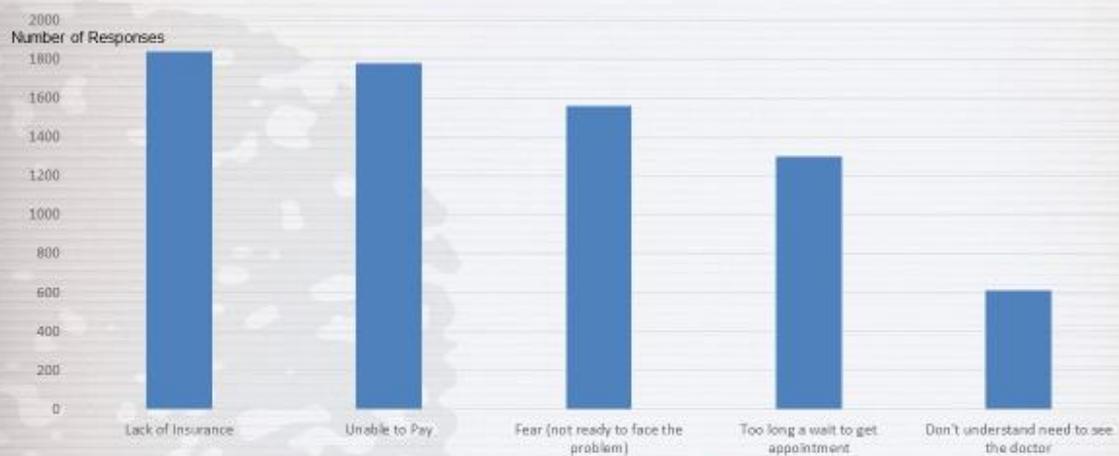
**Q: What are the biggest health issues or concerns in your community (select top 3)?  
Top 5 Responses**

N=3561 Total Surveys



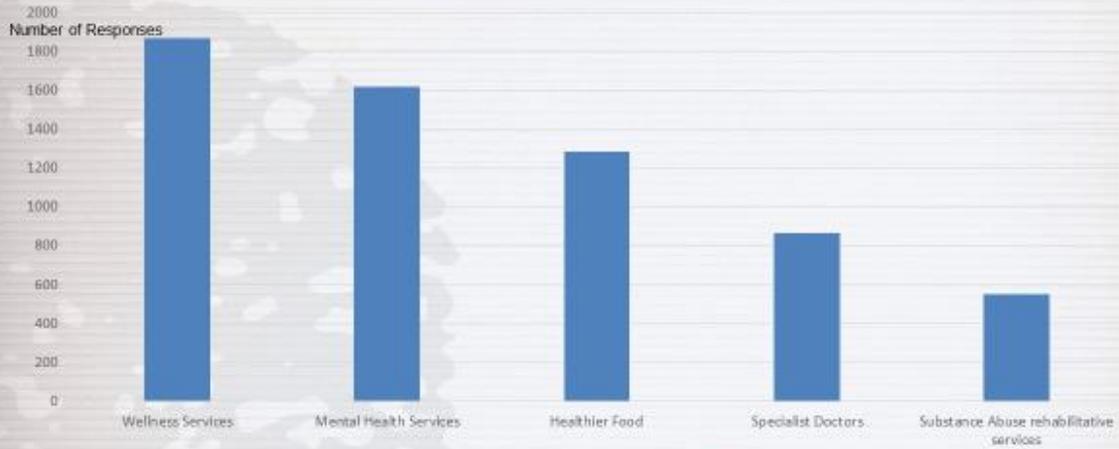
**Q: What keeps people in your community from seeking medical treatment (select top 3)?  
Top 5 Responses**

N=3561 Total Surveys



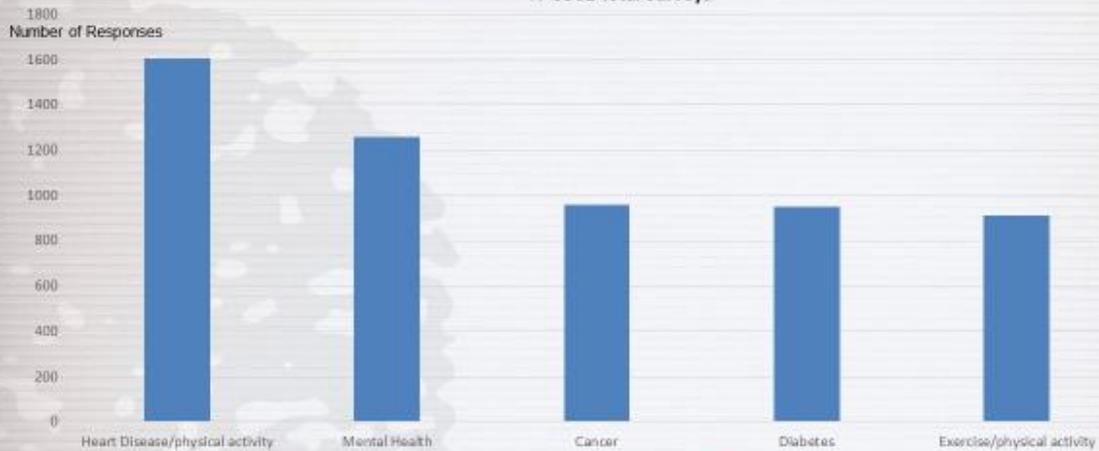
**Q: What is needed to improve the health of your family and neighbors (select top 3)?**  
**Top 5 Responses**

N=3561 Total Surveys



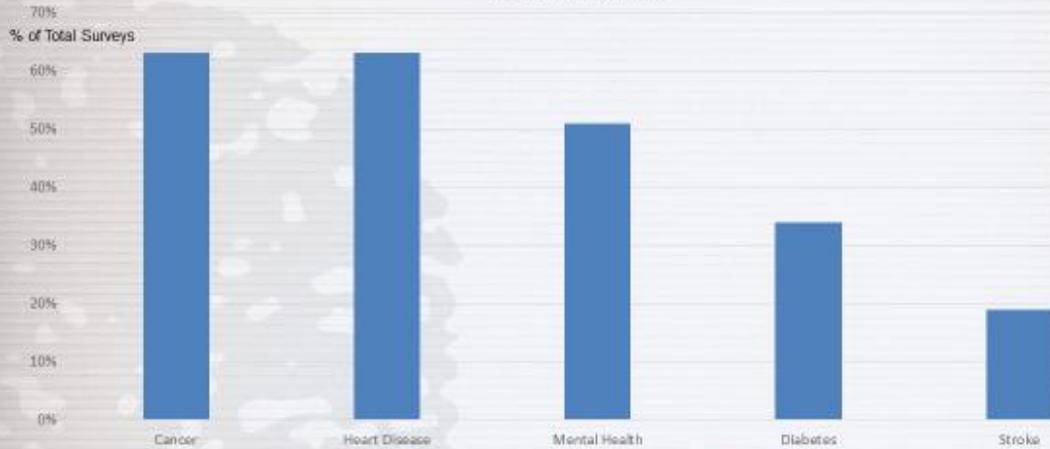
**Q: What health screenings or educational / informational services are needed in your community (select top 3)?**  
**Top 5 Responses**

N=3561 Total Surveys



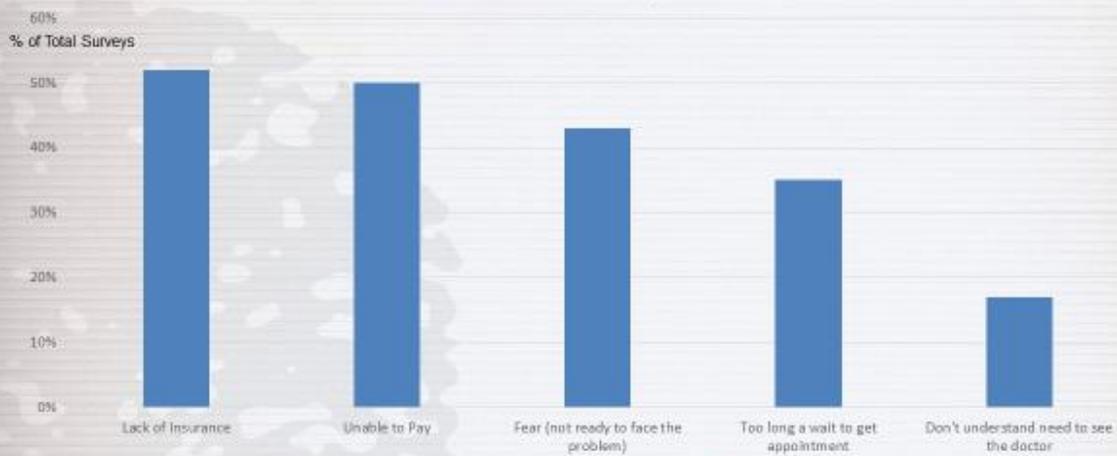
**Q: What are the biggest health issues or concerns in your community (select top 3)?**  
**Top 5 Responses**

N=3561 Total Surveys



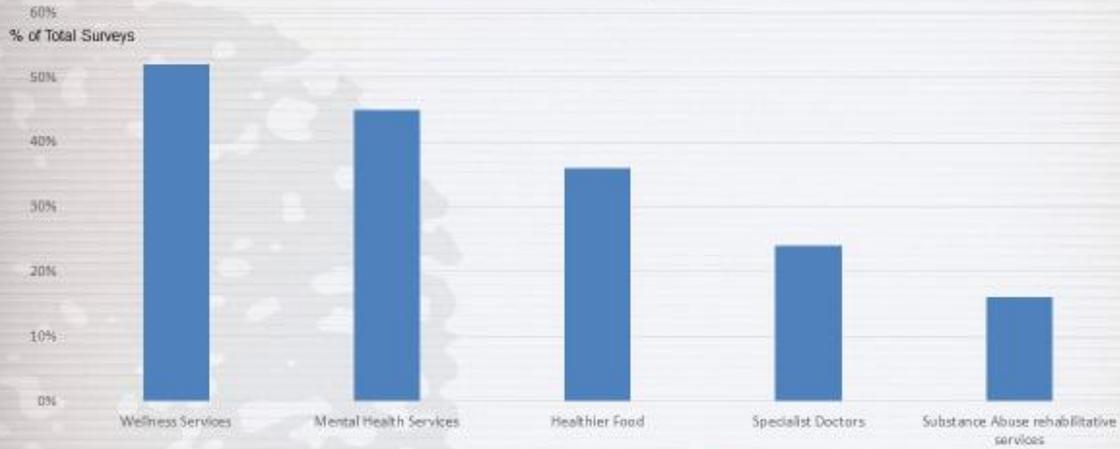
**Q: What keeps people in your community from seeking medical treatment (select top 3)?**  
**Top 5 Responses**

N=3561 Total Surveys



**Q: What is needed to improve the health of your family and neighbors (select top 3)?**  
**Top 5 Responses**

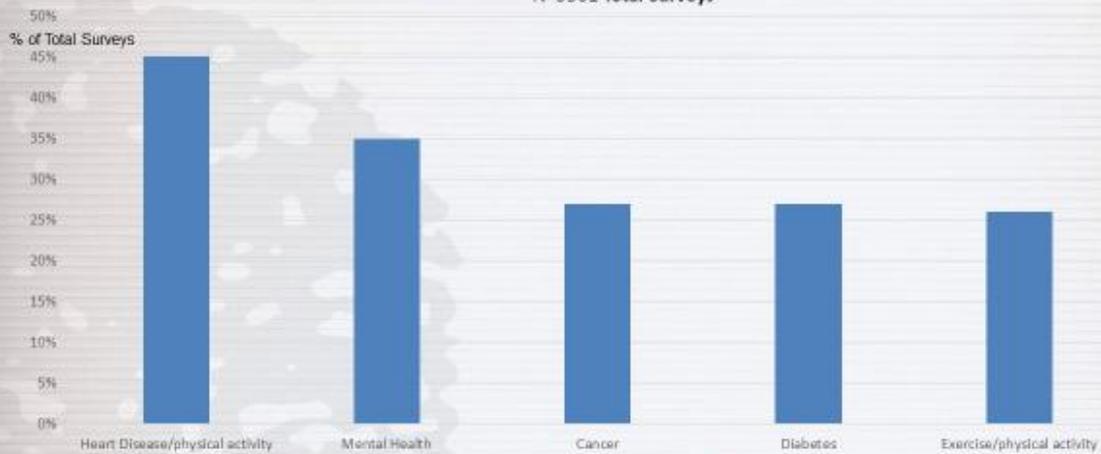
N=3561 Total Surveys



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**Q: What health screenings or educational / informational services are needed in your community (select top 3)?**  
**Top 5 Responses**

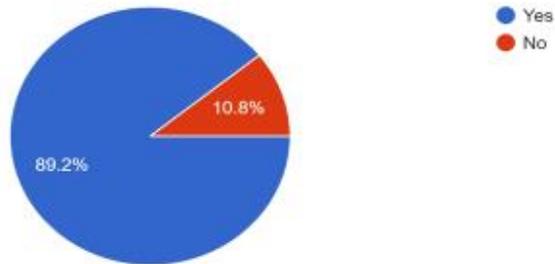
N=3561 Total Surveys



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Have you had a routine physical exam in the last two years?

3,584 responses



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Over the past two weeks, how often have you felt down, depressed, or hopeless?

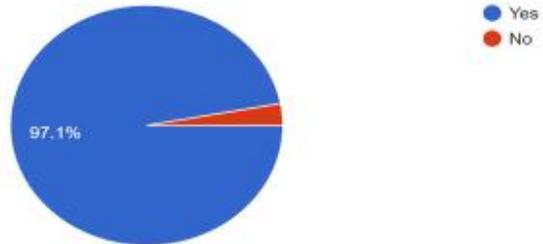
3,584 responses



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Do you consider your neighborhood to be a safe place to live? Consider your neighborhood to be the area within 5 minutes walking distance from your home.

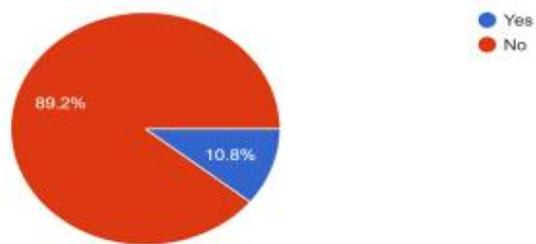
3,584 responses



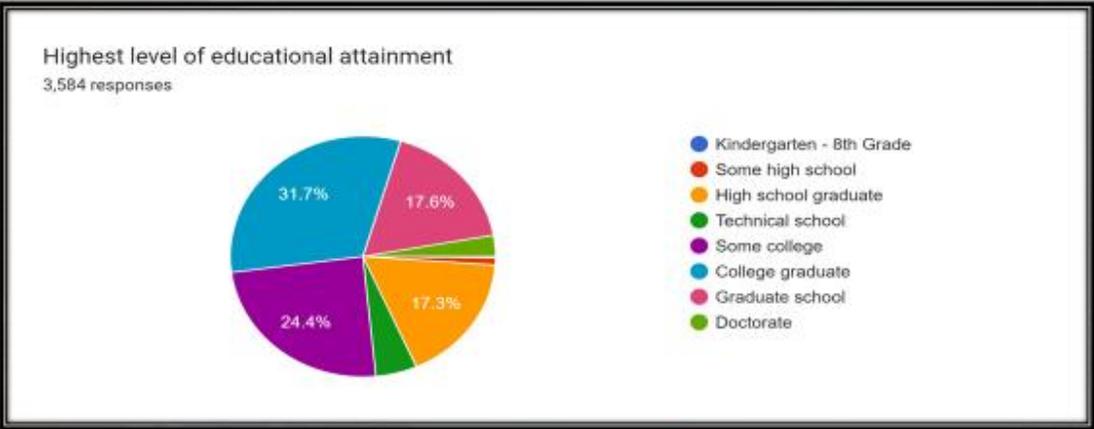
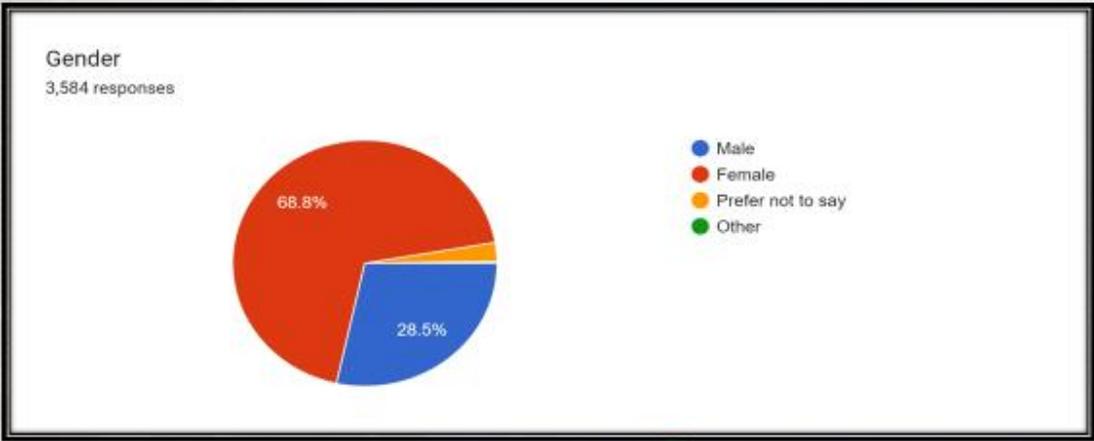
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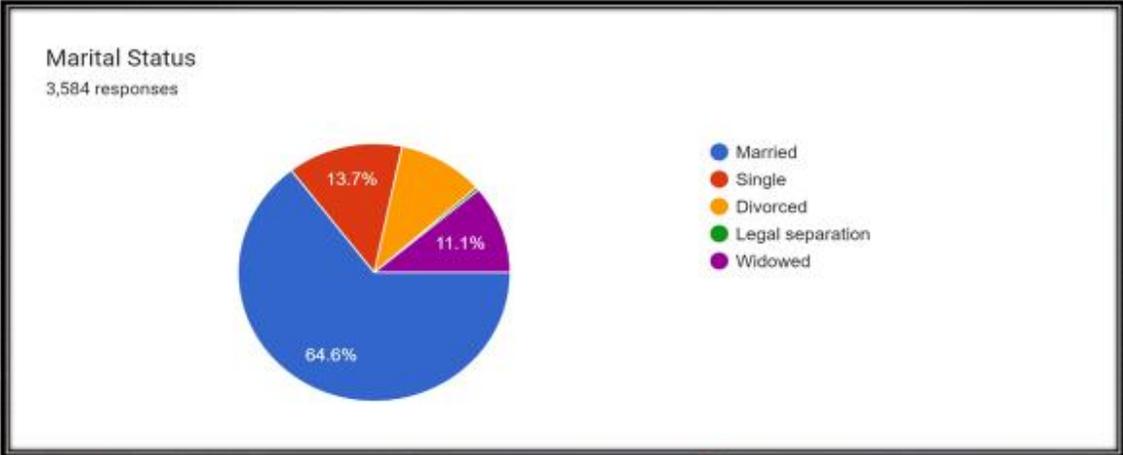
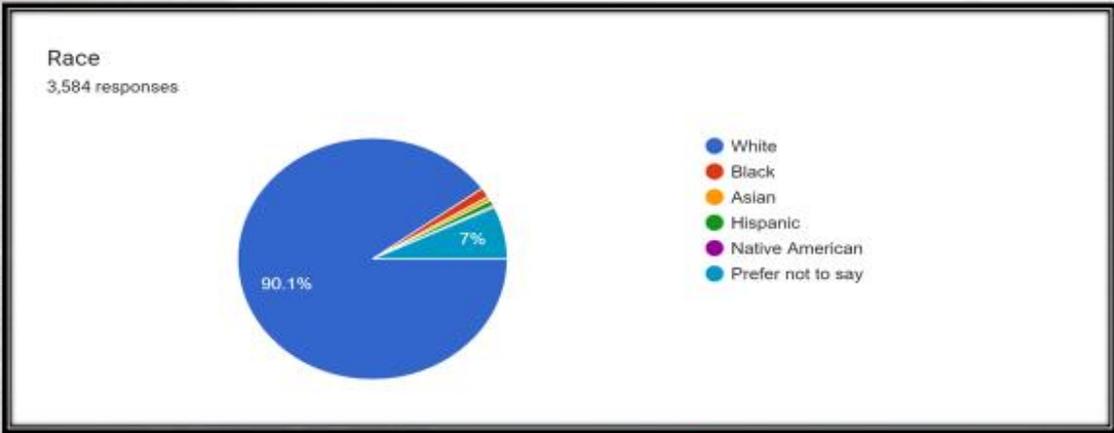
Within the last 12 months, have you worried that your food would run out before you got money to buy more?

3,584 responses



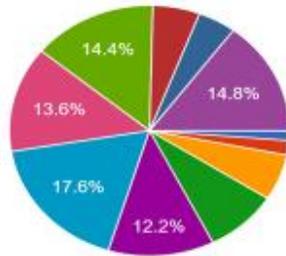
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### Yearly household income

3,584 responses



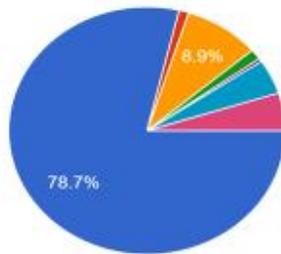
- Less than \$10,000
- \$10,000 to \$14,999
- \$15,000 to \$24,999
- \$25,000 to \$34,999
- \$35,000 to \$49,999
- \$50,000 to \$74,999
- \$75,000 to \$99,999
- \$100,000 to \$149,000

▲ 1/2 ▼



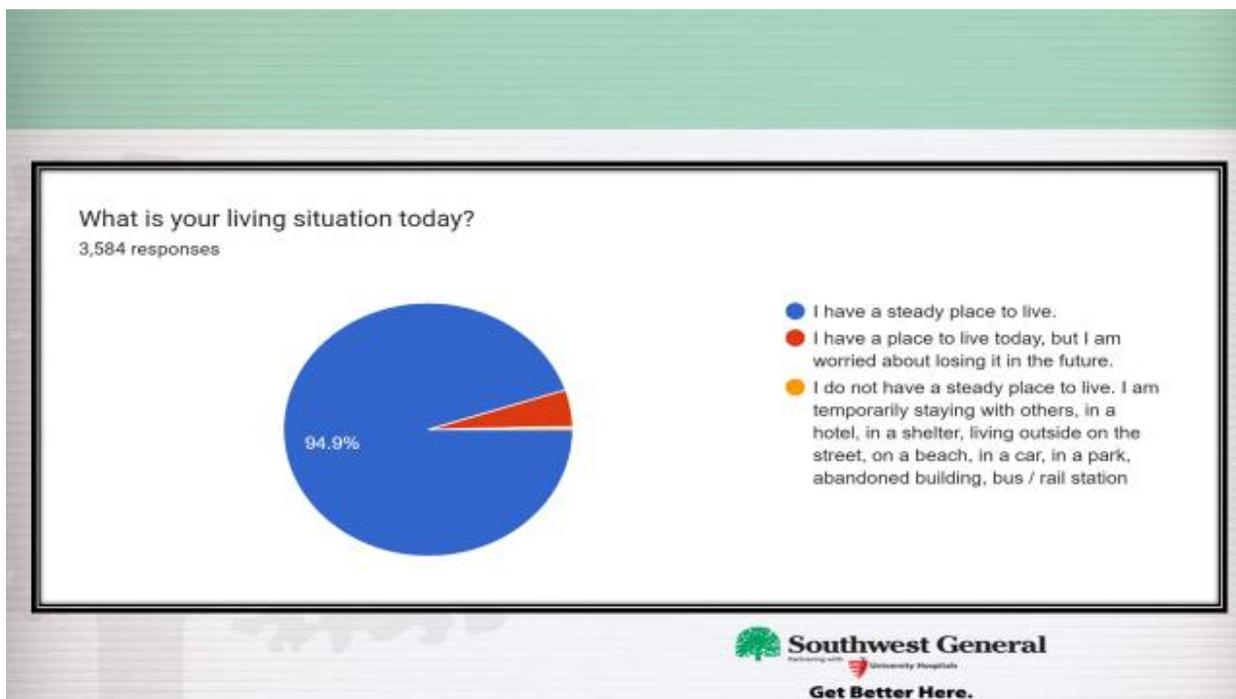
### Disability Status

3,584 responses



- No disability
- Sensory disability only
- Physical disability only
- Mental disability only
- Selfcare disability only
- Mobility disability only
- Two or more disabilities





The Survey provided an opportunity for individuals who participated in the survey to answer three questions pertaining to community needs. There were many duplicate responses to the questions, below is just a sample of what was shared.

**What activities exist or what else can be done to address issues of structural racism in our area?**

**Structural racism is defined as the ways in which society fosters racial discrimination through mutually reinforcing systems of housing, education, employment, earnings, benefits, credit, media, healthcare, and criminal justice.**

- Education of young and attrition of older generation that was inbred with racial ideas
- Less tolerance from racial majority (Caucasian) –it’s pervasive but the change must come from within the larger group and we should speak up when we hear/see prejudice occur
- Universal Healthcare and nutritional education
- Free health seminars and invite people of all races to attend
- We need to foster inclusion in our neighborhoods and learn about cultures different from our own. We are all human.
- Explain about discrimination and racism to the people at local meetings. I have never really known what RACISM is exactly
- Structural racism can only be fought by individuals at every level
- Stop relating problems/crimes to ethnic groups. A crime is a crime
- I don’t know, I don’t have an answer
- Start looking at people the same, as human beings, not blame the color of their skin as the problem
- Focus on teaching acceptance
- Communication and discussion

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**Please list anything else that you think your community needs when it comes to healthcare or any other comments that you have about your community's health and wellness.**

- Food banks
- More health care professionals
- More education on the safety of vaccines and health screenings
- More help for mental illness
- More transportation
- Affordable health care
- Mental health checks for children and adults
- More social services
- Affordable prescriptions
- Education on reproduction rights
- Better nutrition
- Free transportation
- Better access to primary care
- Better access to addiction counseling for families impacted
- More services available after 6pm
- Meal delivery for those unable to go out
- Free health screenings and more services at a reasonable price
- Drug awareness
- Follow-up reminders for preventive services



**How has the COVID-19 pandemic impacted your health and wellbeing?**

- Isolation
- No change
- Weight gain
- Negatively
- Depression
- Fear
- Anxiety
- Stress of catching/transmitting
- Lack of social activities
- More cautious
- My mental health
- Postponed surgery
- I'm afraid to go places with large crowds
- Sad
- Separation from a dying patient
- Lost my loved-ones
- I feel like a prisoner in my home
- Frustrated



## Next Steps: Southwest General Health Center

# CHNA data used to inform SWG Prioritized Health Needs

### ★ SWG Prioritized Health Needs 2023

Cuyahoga County 2022 Prioritized Health Needs 

Rank	Significant Health Need Area	
1	Behavioral Health (Mental Health and Drug Use/Misuse)	★
2	Structural and Institutional Racism	★
3	Accessible and Affordable Healthcare	★
4	Access to Healthy Food	★
4	Community Safety	★
5	Maternal, Fetal, & Infant Health	★
6	Economic Concerns	
7	Environmental Health	
8	Older Adults	★
9	Education	★

**CHNA 2022 Priorities selected** for the next Cuyahoga County community health improvement plan:

- Structural and Institutional Racism (overarching theme)
- Trust (overarching theme)
- Behavioral Health ★
  - Mental Health
  - Drug Use/Misuse
- Accessible and Affordable Healthcare ★
  - Access to Healthy Food ★
  - Community Safety

### SWG 2022 CHNA Survey Results

Survey Question	% Survey Response	Number of people impacted - extrapolated to total population of 90K	
Disabled (Physical/Mobility/Self Care/2 or more)	21%	18900	★
Transportation Issues	15%	13500	★
Food Insecurity	11%	9900	★
Housing - Place to live but worried about losing	5%	4500	

Health Equity Steering Committee

Southwest General Health Center will build action plans and work with the community based organizations and others on providing opportunities to meet the needs of the individuals they serve.



ST. VINCENT CHARITY  
MEDICAL CENTER

*A Ministry of the Sisters of Charity Health System*

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## Evaluation of Impact

## St. Vincent Charity Medical Center

St. Vincent Charity Medical Center is the city's only faith-based, acute-care teaching hospital, caring for the community since 1865. Faithful to the philosophy and heritage of the Sisters of Charity of St. Augustine, St. Vincent Charity is committed to the healing mission of Jesus, serving with a deep respect for the dignity and value of all persons, practicing quality care, a dedication to the poor and a commitment to education.

St. Vincent Charity is located in the Central neighborhood, one of Cleveland's most economically disadvantaged areas, with a median household income of \$10,440 equating to 86% of residents living in or near poverty. The makeup of the neighborhood is mostly single parent households and older adults with a dense population of public housing, limited convenient access to healthy food (no grocery stores), and extremely limited internet access. Yet, in spite its many challenges, the community is resilient and boasts numerous assets including community gardens, grassroots organizations committed to advocacy, dedicated churches, a close proximity to two higher education institutions and the prospect of impactful community development through new investment in the neighborhood.

In order to address the needs of the community, St. Vincent Charity was part of a collaborative process with healthcare institutions, academia, public health, community organizations and resident voices to develop the 2019 Community Health Needs Assessment (CHNA). The top health needs were identified through relevant data collection and analysis along with critical stakeholder input. The identified health needs align with the State Health Assessment (SHA) and State Health Improvement Plan (SHIP). St. Vincent Charity adopted the CHNA in October 2019. Subsequently, an Implementation Strategy was developed and adopted in April of 2020 to address the priority health needs of the community which include:

- 1) reducing chronic disease and its effects
- 2) addressing community conditions
- 3) enhancing mental health and reducing substance abuse
- 4) eliminating structural racism\*
- 5) enhancing trust\*

\*These are long-term, cross-cutting strategies that will be integrated into each of the other priority areas. Plans to address these fundamental contributors to health were also created.

An evaluation of the impact of strategies utilized to address the health priorities was conducted for 2020-2022. Progress toward longitudinal goals takes sustained efforts and effects may take multiple community health needs assessment cycles to be realized. This cycle was impacted by the Coronavirus (COVID) pandemic as many strategies were adapted due to urgent needs in the hospital and community.

St. Vincent Charity was on the front lines of the pandemic caring for patients every day and adapting services to meet the recommendations of state and federal government. True to its mission, St. Vincent Charity cared for the community through its work to provide COVID testing, acute care of those affected by COVID, outreach into the community to provide Personal Protective Equipment (PPE), vaccines to caregivers and the community, and close collaboration with other hospitals and healthcare providers to coordinate the response to the pandemic.

COVID testing was made available to the community, patients and caregivers not only at the hospital but through multiple access points at satellite locations and long-term care facilities. A total of 33,226 tests were administered requiring 7,955 caregiver hours between 2020 and June 2022.

St. Vincent Charity received 12,000 COVID vaccines. Vaccines were provided to caregivers per guidelines and then community vaccine clinics were established with specific outreach to those disproportionately affected by

COVID requiring 3238 caregiver hours. Vaccine doses were also provided to Federally Qualified Healthcare Centers and health departments to increase the reach of vaccine availability in the community.

St. Vincent Charity's community response also included the distribution of 40,000 masks and 4,500 PPE kits containing hand sanitizer, personal hygiene items and COVID resource information. These resources were provided to patients, at food distribution sites, churches, senior living communities and public housing. Kits were also provided to grassroots organizations who continued their outreach into the community during the pandemic.

The pandemic forced all healthcare institutions to meet urgent medical needs while also adapting their strategies and efforts to address the health priorities identified in the 2019 CHNA. Action steps were tailored to meet the community's needs during this challenging time. The disparity of COVID infection rates and vaccine availability along with loss of employment, food insecurity, lack of connectivity, housing instability, and increased mental health needs all negatively affected the community. St. Vincent Charity pivoted resources to address the social determinants of health as described in the action steps below while also addressing the priority health needs identified in the CHNA.

### **Priority Health Needs and Action Steps**

#### **1) Reducing chronic disease and its effects**

##### **Action Steps**

St. Vincent Charity addressed chronic disease through increased awareness, on-going support and education to help patients and the community live healthy lives.

##### **Bariatric Surgery Center**

In light of the link between obesity and chronic medical conditions, programs that focus on helping patients reach their weight goals are critical for prevention and management. In 2022 the Bariatric Center marked its 25<sup>th</sup> year of accreditation as a national center of excellence by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP®). St. Vincent Charity's Center for Bariatric Surgery was the first program in northeast Ohio to achieve national accreditation and continues to be a highly sought-after center for surgical and non-surgical weight loss. In addition to meeting all necessary criteria, the Center for Bariatric Surgery was recommended for 'Best Practice in Patient Education Award' for going above and beyond to provide patient support groups and ongoing education. The Bariatric Support Group adapted to COVID by pivoting to virtual meetings with 9 meetings and 200 attendees in 2021. The Bariatric Surgery team provided care to 466 patients from January 2020 – June 2022 on their journey to better health. Non-surgical weight management visits increased 35% between 2021 and 2022 offering medical management and nutrition counseling with a goal of not only weight loss but behavioral change for success.

##### **Health Screenings**

Health screenings were limited due to COVID but continued in targeted high risk zip codes at food distributions, outdoor events and senior living communities per Centers for Disease Control and Prevention (CDC) guidance. These touch points became even more important due to the pandemic and the interruption in routine care appointments. Many participants were encouraged to make follow up appointments with their providers, others were linked to social services and a small number were directed to Emergency Care for critical values.

Total health screenings to assess for diabetes and hypertension, including personalized education were as follows:

- 2020 - 351 participants
- 2021 - 355 participants
- 2022 - on par to surpass 450 participants

### **Diabetes Support Group**

The St. Vincent Charity “Sweet Life” Diabetes Support Group, in its eighth year, adapted to the COVID restrictions with a resilient spirit including:

- 1 in person meeting and 5 virtual meetings in 2020
- 8 virtual meetings in 2021
- 4 virtual meetings in 2022 with 4 hybrid meetings
- Average meeting attendance: 15-20 participants

The learning curve of virtual meetings was embraced by the majority of the group. As time went on, more and more participants were able to join using video on a computer or smart phone, which improved meeting quality. The group was steadfast through the pandemic continuing to discuss their diabetes management journey and how they were coping with the uncertain times.

### **Internet Access/Digital Literacy**

In light of the lack of connectivity in the neighborhood with 1 in 2 households in Central without an internet subscription in 2019, St. Vincent Charity worked with DigitalC to improve capacity. DigitalC is a Cleveland non-profit supporting the initiative of EmpowerCLE+. EmpowerCLE+ brings reliable, high-speed broadband internet to Cleveland’s under-connected and unconnected communities. St. Vincent Charity agreed to host an internet transmitter on its roof in 2017 followed by the 2020 installment of an additional transmitter at Cedar High Rise. As a result, the coverage area significantly improved. DigitalC then began the process of rolling out technologies to bring access to additional households not reached by the existing transmitters. During conversations with DigitalC, St. Vincent Charity was introduced to PC’s for People. PC’s for People is a non-profit whose mission is to provide refurbished PC’s, training and support to those households that cannot afford the technology and services. The combination of equipment, training and improved internet access in close proximity to St. Vincent Charity has been a key driver to improving connectivity for our patients. Diabetes Support Group participants were linked to free computers, along with digital literacy classes and access to reduced cost internet services.

## **2) Addressing community conditions**

### **Action Steps**

The social determinants of health make up 80% of the contributing factors to health outcomes according to a study cited by the National Academy of Medicine. Social determinants include healthcare, financial stability, education, social/community life and where a person lives. St. Vincent Charity has always been responsive to the needs of patients and the community beyond medicine. Addressing legal needs, food insecurity, transportation, connectivity and education during the pandemic were imperative to the health of the community.

## Medical-Legal Partnership

- A medical-legal partnership was established in late 2017 between The Legal Aid Society of Cleveland and St. Vincent Charity to integrate the unique expertise of a lawyer and paralegal into the healthcare setting, to address civil legal needs related to social determinants of health. All St. Vincent Charity patients and their households have access to this service.
- In 2020, the St. Vincent Charity medical-legal partnership (MLP) handled 93 legal cases for 79 different patients including housing conditions, record sealing, public benefits and family law. These numbers reflect multiple patients who had more than one legal issue addressed by the program.
- When a patient is referred to the MLP, a complete legal check-up is conducted to holistically address the civil legal health of the patient and eliminate these barriers to health.
- As a result of COVID, the MLP rapidly, and effectively, transitioned to a remote program in March of 2020. Intakes previously completed at patients' bedsides, client meetings, and court hearings occurred virtually through zoom or telephone. Through patient-clients, the Legal Aid team quickly identified gaps in service from community partners, including lack of connectivity, lack of access to libraries for copying and printing services to submit verifying documents to agencies for utilities and financial assistance, lack of affordable housing, food insecurity, and lack of resources for the unhoused. As referrals to the MLP decreased, Legal Aid devoted more time to advocacy on these issues in the community.
- In 2021, the MLP handled 137 cases for 107 unique clients. This increase in cases reflects both increased census at the hospital and increased capacity of the MLP through the addition of a paralegal. Increased case numbers in 2021 are also the result of targeted outreach through expansion of the program to the Outpatient Behavioral Health Clinic. Additionally, a pilot program was created to increase screening and identify civil legal needs of patients in the Healthcare Center and the Psychiatric Emergency Department. Observations and outcomes from this pilot project were shared at the 2021 Loyola Health Law Symposium and were published in the *Summer 2022 Annals of Health Law and Life Sciences*, a publication of the Loyola University Chicago Law School. Co-authors on this project include St. Vincent Charity providers Dr. Keyvan Ravakhah and Dr. Edward Kilbane.
- 2021 saw a rapid increase in evictions and housing conditions cases as the CDC Eviction Moratorium came to an end. Most common case types continued to be related to federal subsidized housing, public benefits, record sealing, and family law issues.
- The MLP continued to regularly provide education to St. Vincent Charity providers, and to the Greater Cleveland community, on the civil legal issues that face patients and their neighbors. One unique training took place at St. Vincent Charity for Cleveland Police cadets to learn about the collateral consequences of criminal convictions, evictions, and incarceration, particularly on people living with mental illness and/or economically disadvantaged.
- The Legal Aid team returned on-site two days per week in 2022. It maintains a consistent stream of referrals and continues to connect with patients where and when they need legal assistance. In the first quarter, the MLP handled 58 cases for 48 unique

patients. The most common case types were private landlord/tenant, federally subsidized housing, and SSI.

### **On-Demand Transportation**

- In 2017, St. Vincent Charity created an on-demand, non-emergency medical transportation solution using Uber drivers (now Lyft) to help patients travel between medical appointments in a safe, convenient, and reliable way.
- The solution was created in response to the lack of reliable transportation available to patients in outpatient chemical dependency treatment programs. Shortly thereafter, this solution was used in all hospital units, including diabetes education and psychiatric units, where patients could not obtain another method of transportation. With the majority of St. Vincent Charity patients receiving Medicaid or Medicare as their primary insurance, and given the volatility of life for a person early in recovery from drugs and alcohol, this transportation service is critical to providing safe and consistent access to life-saving care. This service was available throughout COVID albeit there were time periods when driver availability was limited.
- In 2020, St. Vincent Charity provided 5,732 successful rides for a total of 54,611 miles traveled.
- In 2021, St. Vincent Charity provided 5,797 successful rides for a total of 49,390 miles traveled.
- In the first six months of 2022, St. Vincent Charity provided 3,198 successful rides for a total of 26,350 miles traveled.

### **Mission Kitchen**

- Recognizing a lack of access to healthy meals in the community, along with 86% of families living at or below poverty in the Central neighborhood, St. Vincent Charity started The Mission Kitchen. The Mission Kitchen is an extension of the Department of Mission and Ministry utilizing the skill, knowledge, passion, and resources of St. Vincent Charity's Dietary Services and caregivers to form meaningful, lasting, and impactful relationships with the local community through food and meal donations. 100% of funding has been received from private donations from caregivers and supporters of the hospital.
- The Mission Kitchen worked with the Cleveland Metropolitan Housing Authority and Cleveland Municipal School District to deliver 2,401 meals in 2021 to Central neighborhood residents.
- In 2022 the Mission Kitchen has served over 1200 meals through June consisting of both delivery of meals and a monthly community meal at the Friendly Inn, a trusted community partner.

### **ReFresh Pantry**

- As the Central neighborhood struggled with COVID challenges and convenient access to healthy food (no grocery stores), St. Vincent Charity began a monthly outdoor food distribution program. In partnership with the Greater Cleveland Food Bank, the program runs from May – September. Because 80% of the factors that influence health

happen outside the walls of a hospital, it was important to address the need for healthy food.

- The distribution provides fresh fruits and vegetables, shelf stable products, PPE, clothes, community resources, boxed lunches, and health screenings. 795 people were served totaling 7155 meals in 2021. 16% of the households served received food assistance for the first time at St. Vincent Charity.
- With 9 in 10 Central residents eligible to receive food bank benefits it is important to make this resource available. The ReFresh Pantry continued in 2022 from May through September. In May – July over 330 households received food, impacting 600 residents totaling 5238 meals.
- In an effort to increase vaccination rates in Central COVID vaccines were available at the 2022 distributions through a partnership with the Ohio Department of Health.

### **Health Literacy**

- The Health Literacy Institute was created in 2007 after receiving a grant to institutionalize health literacy across the continuum of patient care. Health literacy refers to a person’s ability to obtain, understand, and process basic information, which empowers them to make appropriate health decisions.
- The St. Vincent Charity Patient and Family Education Policy directs staff to provide patients and families with tools to manage their health through easy-to-understand written and verbal communication. Keys to this effort include plain language and Teach-Back.
- A study to assess caregiver knowledge of Teach-Back, evaluate and address barriers, and measure patients’ recall of engaging in this learning method was conducted. The study was shared in *HLRP Health Literacy Research and Practice 2021*. Co-authors include St. Vincent Charity caregivers Karen Komondor RN,BSN,CCRN and Dr. Ryan Choudhury. Lessons learned include a gap between provider self-reported use of Teach-Back and patient recall. Factors identified included caregiver barriers of time and patient appropriateness during illness to using Teach-Back and assessment of patients throughout the hospital continuum of care (patients who may not have yet been offered education). Results confirmed a need to provide consistent education to caregivers to address barriers and misconceptions of Teach-Back.
- In 2020 St Vincent Charity continued with health literacy trainings through annual competencies of all caregivers.
- In 2021 a targeted workshop with all Medical Residents was provided including didactic, videos, role play and plain language exercises. All clinical managers participated in this training in 2022.

## **3) Enhancing Mental Health and Reducing Substance Use**

### **Action Steps**

COVID exponentially increased the rates of those suffering with mental health issues along with the need for providers to identify and met those needs. In response St. Vincent Charity collaborated with partners, enhanced mental health screening, expanded access to services, added providers and offered telehealth.

## **Community Collaboration**

- St. Vincent Charity is part of a consortium led by The Center for Health Affairs to reduce the impact of the opioid epidemic in Northeast Ohio through promoting policy change, increasing prevention efforts and sharing and implementing evidence-based practices. Examples include education of hospital employees, use of medication-assisted treatment (MAT) and expanded distribution and use of Naloxone.
- A strong partnership with the Alcohol, Drug Addiction & Mental Health Services (ADAMHS) Board of Cuyahoga County aligns St. Vincent Charity's work with other partners to more effectively and efficiently serve the community.

## **SBIRT (Screening, Brief Intervention, Referral to Treatment)**

- The purpose of SBIRT is early detection and intervention for alcohol and drug use, depression, anxiety, and trauma. Currently the SBIRT team interacts with patients seen in the outpatient healthcare clinic as well as patients admitted to the 5B medical-surgical unit. The SBIRT team consists of one LSW and one LISW-S. The unit RN's have also been trained in SBIRT screening.
- The following screening tools are used in SBIRT:  
DAST: illicit drug use/abuse, AUDIT: alcohol use/abuse, PHQ-9: depression and suicide, GAD-7: anxiety, PCL-5: trauma
- Based on the outcome of the screening, patients are offered referrals to the appropriate healthcare providers or services. In most cases these include outpatient behavioral health and/or outpatient chemical dependency services.
- In 2020 619 patients were screened, 42 were provided treatment recommendation and 15 accepted the referral.
- In 2021 1679 patients were screened, 852 were given treatment recommendation and 358 accepted the referral.
- In 2022 (1<sup>st</sup> 5 months) 1683 patients were screened, 240 were given treatment recommendation and 110 accepted the referral.

## **Rosary Hall**

- Provides seamless care for individuals suffering from addiction through a process of inpatient medical withdrawal/detoxification to outpatient rehabilitation and community-based support networks.
- Offers acute hospital detoxification and sub-acute detoxification, intensive outpatient treatment averaging 8 weeks and non-intensive outpatient for 12 weeks, followed by connections to 12-step community programs and individual counseling.
- Vivitrol Medication Assisted Treatment was added in 2020 with support from the ADAMHS Board for the uninsured and those with Medicaid due to exclusion of this medicine for reimbursement. Rosary Hall also offers Suboxone and Sublocade treatment. The ability to offer options provides for better health outcomes and retention.
- In 2021 the following services were added:
  - Telehealth in response to COVID

- 24-7 intake and access for Rosary Hall and inpatient behavioral health allowing for a more effective and efficient care response
- Peer support specialists in Rosary Hall outpatient and detoxification.

#### **Psychiatric Emergency Department (PED)**

- The only PED in Northeast Ohio and 1 of only 2 in the state.
- Treats thousands of patients each year, many of whom exhibit suicidal behaviors. PED crisis intervention services decrease the number of suicide attempts in the community as a result of suicide risk-assessments, education and linkage to follow-up treatment.
- Access to patients who walk in, are brought by EMS, Mobile Crisis Team, law enforcement along with the county courts, jails, and public safety agencies.
- Patients often have concurrent chemical dependency and mental health diagnoses, and for many of them the PED may be the first step on the path to recovery.
- Staffs a Mobile Crisis Social Worker who links patients to the most appropriate services upon discharge to reduce readmission.

#### **Outpatient Mental Health Clinic**

- Created in 2021 to meet the growing need for mental health outpatient services. The care team includes psychiatry, psychology, social work, counseling, care coordination and medication management.
- The clinic focuses on caring for the physical, mental, emotional and spiritual health of the patient.
- Volumes have increased 129% from 2021 to 2022.

### **4) Enhancing Trust and Trustworthiness**

#### **Action Steps**

##### **Community Advisory Board**

- In 2019 St. Vincent Charity created the St. Vincent Charity Community Advisory Board (CAB) with the primary and enduring goal of fostering trust between the hospital and surrounding underserved communities, through consistent engagement and meaningful communication. Members of the CAB represent a diverse group of over 20 organizations including community advocates, residents, local government, healthcare, grassroots organizations, education, safety and the faith-based community.
- In 2020, the CAB expanded on its long-term goal with the intent to identify, quantify, and prioritize more immediate challenges facing the residents of the Central neighborhood and adjacent communities. Once prioritized the CAB develops achievable solutions and initiatives that can be launched swiftly and have a rapid impact.
- Initiatives:
  - **PPE:** Shortly after the pandemic began in early 2020, the CAB facilitated the acquisition and successful distribution of tens of thousands of personal

protective equipment (PPE) units in the Central and surrounding marginalized neighborhoods.

- **Access to Care:** Prior to the pandemic, *access to healthcare* was a significant challenge for marginalized communities, made even more difficult during the pandemic. To lessen that burden and provide easier access to SVCMC's clinical services, the CAB played an informative role in the development of a new "one call for all your healthcare needs," access to care line at SVCMC.
- **Mobile Laundry/Internet Hotspot:** The Centers for Disease Control defines Social Determinants of Health (SDOH) as conditions in the places where people live, learn, work, and play that affect a wide range of health and quality-of-life risks and outcomes. The SDOH in Central and surrounding neighborhoods have left residents grappling with health disparities associated with generational poverty, toxic stress, and higher incidences of chronic health conditions as well as the historic inequalities. Based on primary and secondary research, feedback from members of the CAB, and results from a broader community survey, access to basic laundry services and affordable internet were identified as critical and pervasive needs.
  - To meet the significant need for laundry services and internet access in Central, the CAB is planning to implement a mobile laundry with hotspot capabilities in late 2022. The mobile laundry will provide access to no-cost services for over 12,000 residents of Central and surrounding communities and the hotspot will provide free, localized access to the internet.
  - In addition to basic laundry services and free internet access, additional resources will be available at the laundry site. Examples include:
    - Identify health/social needs and make real-time connections to services
    - Education support: provide homework assistance and activities to occupy little hands and minds.
    - Health screening to identify basic primary and mental health needs
  - The CAB is pursuing federal and local funding to support the mobile laundry/internet hot spot initiative: requests for Congressionally Directed Spending have been proposed through the office of U.S. Senator Sherrod Brown and the administrations of both the City of Cleveland and Cuyahoga County.

## 5) Eliminating Structural Racism

### Action Steps

- Eliminating Structural Racism is an aligned strategy being worked on by healthcare institutions, academia, public health, community organizations and residents. In

- addition to this combined work, St. Vincent Charity under the Sisters of Charity Health System has been dedicated to addressing this important public health crisis.
- In 2020 SVCMC, with more than 20 Greater Cleveland organizations, signed a declaration of racial equity and inclusion and pledged to address racism as public health crisis. This was followed by Cleveland City Council declaring racism as a public health crisis. The city will now be required under CDC guidelines to take action to eliminate disparities. Cuyahoga County also passed a resolution declaring racism a public health crisis and committed resources to address racism and eliminate disparities.
  - In 2021 the Sisters of Charity Health System joined the Catholic Health Association of the United States in a new initiative committed to achieving health equity by confronting racism. This commitment is shared by 22 of the nation's largest Catholic healthcare systems committed to eliminating structural racism.
  - After the murder of George Floyd, leaders within the Sisters of Charity Health System recommitted themselves to their DEI efforts by first listening to each of the several thousand caregivers of the System (through a survey), and then responding to what was shared through a new initiative that included four "pillars." These pillars have guided health system efforts over the last year-and-a-half. The DEI team is now revisiting and updating that strategy, incorporating what was learned and expanding the work to better respond to caregiver needs.
  - The four pillars begin with a commitment to *DEI Graced Conversations*. In response to the survey, our DEI Committee proposed meaningful conversations as an important element for any DEI program in the health system. There are many challenges associated with a system-wide effort. Since different ministries are in different places on this journey, facilitation and conversation-starting materials could look different for different organizations and perhaps even different within parts of a single ministry. Facilitation and discussion standards are currently being developed for these conversations as well as facilitator training.
  - Second, the DEI team has worked to provide *DEI Educational Opportunities*. There was no single understanding of DEI content and definitions and peoples' training in this area was uneven and came from many sources. There was clearly a need to agree on particular terms and the priority of content going forward. Unconscious bias and cultural competency, especially, are two foundational areas for which we have determined every employee requires training and/or continuing education. Over time, the health system will continue to develop an educational program that will deepen and expand employees' experience and understanding of DEI.
  - A third priority is *Board and Leadership Diversity*. A large group of board and ministry leaders has met several times to discuss board diversity. Some ministry boards have been focusing on diversity for many years while others are at the beginning of this journey. Everyone agrees that board and leadership diversity needs to be a priority going forward. At the same time, many have observed a lack of diversity at all levels of staff leadership. There is now an intentional commitment to diversity across the organization, including opportunities for Human Resource leaders to dialogue with diversity experts and then to implement strategies related

to recruitment, hiring, onboarding, leadership development, and promotion best practices.

- A final priority has been *DEI Purchasing and Construction*. A small group of construction and supply chain leaders have regularly met to determine the best way forward in diversifying our vendors. Our Group Purchasing Organization (GPO) already has a diversity program, but the group has also worked to diversify its non-GPO purchasing, including and especially minority and women-owned businesses that are local. Partnership initiatives and mentoring opportunities are being explored throughout the Health System.



## Evaluation of Impact

## University Hospitals Ahuja Medical Center

UH Ahuja Medical Center is a 144-bed community-based hospital, located in Beachwood, OH, that provides a wide array of inpatient, outpatient, and emergency services to residents of Cuyahoga, Lake, Summit, and surrounding counties. UH Ahuja Medical Center offers 21 full-service specialties and subspecialties, which include emergency services, cardiology, neurosurgery, pulmonology, orthopedics and more. In 2021, most (62.3%) of University Hospitals Ahuja Medical Center's discharges were residents of Cuyahoga County.

### Evaluation of Impact: UH Ahuja Medical Center Community Health Improvement Efforts

The following evaluation of impact pertains to the actions taken since the last Cuyahoga County CHNA in 2019. The assessment was done jointly with the Cuyahoga County Board of Health, Cleveland Department of Public Health and other community partners and aligns with the State Health Assessment (SHA) and State Health Improvement Plan (SHIP). The 2019 Cuyahoga County CHNA was adopted by University Hospitals in September of 2019, and the 2020-2022 Implementation Strategy was adopted in March of 2020. This evaluation report covers the period January 2019 – December 2021. Outcomes from the 2020-2022 period will be further analyzed in early 2023, in order to include 2022 progress in total, and to further inform prospective 2023 implementation strategies.

Upon review of UH Ahuja Medical Center's 2019 Community Health Needs Assessment, hospital leadership isolated three top priority community health needs:

- 1. Improve community conditions**
- 2. Reduce chronic illness and its effects**
- 3. Enhance mental health and reduce substance misuse**

After pinpointing the top priorities, strategies and tactics were created, applying the hospital's staff expertise and resources to combat each community health issue. UH Ahuja Medical Center's objectives are outlined below:

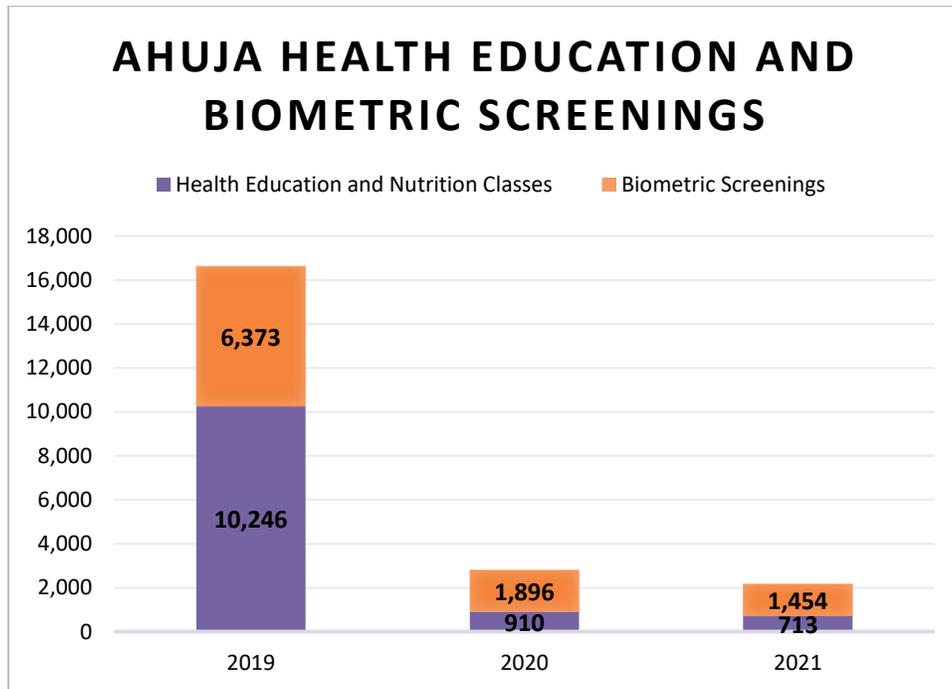
- Educate and screen individuals in targeted locations to increase early detection of chronic diseases, promote prevention, and/or improve treatment compliance
- Implement programs and events to connect individuals with resource providers, reduce food insecurity, increase safety, and expose youth to careers in healthcare professions
- Provide a variety of classes to teach individuals healthy coping mechanisms to manage stress
- Provide a series of physician talks and expos to connect individuals and caregivers with best practices and resources to reduce illegal drug dependency, use, and misuse of opioids

### Impact

In 2019, UH Ahuja Medical Center participated in 155 health education and screening events addressing chronic illness, delivered educational talks and support groups to 10,246 participants and conducted an additional 6,218 biometric screenings by way of events hosted by local corporations, schools, temples and churches, senior centers, low income apartments, community health fairs and rehabilitation centers, and community YMCA locations. To improve community conditions, UH Ahuja Medical Center provided food and other resources to 1,779 families via a Brunch with Santa resource fair, the Summer Lunch Program and by providing Healthy Eating presentations at the local middle school.

Between 2020 and 2021, UH Ahuja Medical Center supported a total of 98 health education talks and support group events, which collectively engaged 2,539 participants. During this time, it also conducted 1,632 biometric

screenings in coordination with local corporations, schools, temples and churches, senior centers, low income apartments, community health fairs and rehabilitation centers, and community YMCA locations.



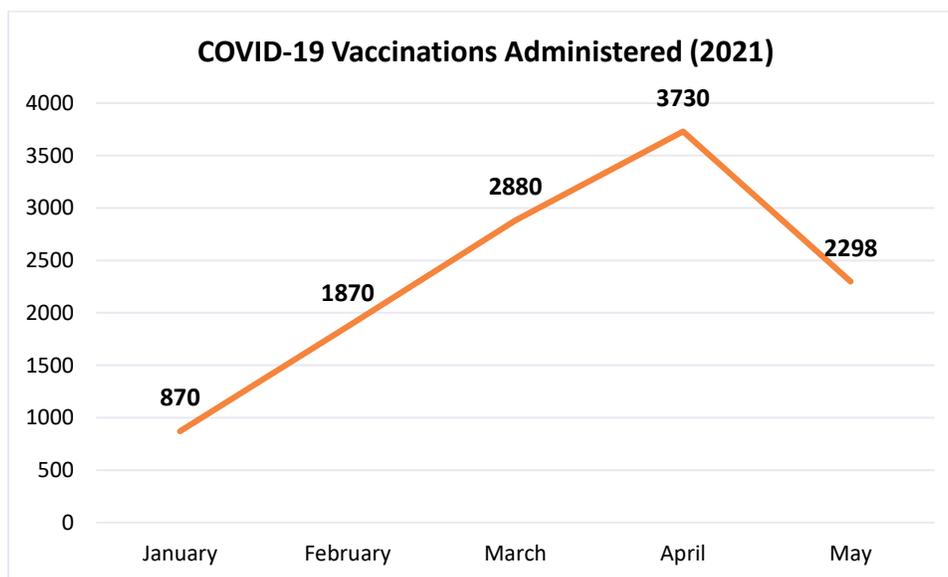
A total of 670 children received free meals as part of the Summer Lunch Program between 2020 and 2021, and more than 800 community residents participated in nutrition classes and support groups that were offered in connection with diabetes and heart education. In response to the COVID-19 pandemic, UH Ahuja Medical Center, in conjunction with other UH hospitals in the East Region and in collaboration with the Cleveland Food Bank, collected 6,285 pounds of food and over \$25,000 in monetary donations to support the Greater Cleveland Food Bank’s “Feeding Our Communities” campaign.

UH Ahuja Medical Center physicians also supported the *Beachwood Medical Academy*, in partnership with Beachwood and Twinsburg schools, in order to expose students to careers in healthcare, and engaged 522 students (in a virtual format) between 2020 and 2021. Finally, UH Ahuja Medical Center provided early disease detection health screenings and, if applicable, referrals and recommendations to 1,760 community residents through 2021.

In response to the COVID-19 pandemic, and in partnership with Geauga Public Health, UH Ahuja Medical Center supported a total of 34 COVID-19 vaccination clinics across the following nine locations in the Chagrin Falls, Chardon, and Burton communities between January and May of 2021.

- Berkshire High School (Burton, OH)
- Chagrin Falls High School (Chagrin Falls, OH)
- Chardon Middle School (Chardon, OH)
- Chardon YMCA (Chardon, OH)
- Gardiner Center (Chagrin Falls, OH)
- Geauga County Fairgrounds (Chardon, OH)
- Geauga Public Health (Chardon, OH)
- Kenston High School (Chagrin Falls, OH)
- West Geauga Middle School (Chardon, OH)

Collectively, these vaccination clinics administered a total of 11,648 COVID-19 vaccinations.



### Hospital Leadership Interviews

In order to provide a qualitative context regarding UH Ahuja Medical Center’s successes and opportunities for improvement related to the implementation strategies, a discussion guide comprised of four anchor questions was utilized to frame an interview with UH Ahuja Medical Center leadership and caregivers on March 31, 2022.

1. Overall, what strategies worked well since their inception, or naturally found traction within the community?
2. What strategies experienced barriers to implementation, or were unable to be implemented?
3. How did the COVID-19 pandemic impact your implementation strategies?
4. Were there new relationships that resulted from the COVID-19 pandemic response that could potentially be leveraged in the future to improve the community’s health?

As a result of these conversations, the following qualitative themes emerged: 1) Community outreach activities shifted during COVID-19 Pandemic, and 2) Value placed on addressing social needs and preventative health despite the obstacles. The following quotes illustrate these themes:

### ***Community Outreach Activities and the COVID-19 Pandemic***

“We haven’t gotten the green light to start having events here where we can invite the community in, so we’ve been finding different locations throughout the community that we can go to and bring everybody there, so we’re working on some flexibility with, hopefully soon, letting at least smaller groups come in.”

“...what had happened is a lot of stuff had gone virtual when the pandemic hit, and from what we were told and what we heard, a lot of things stopped because people weren’t engaging in it, so they weren’t having much success with them, so I think what we’re hoping for now... is that we can move forward with in-person support groups and smaller events.”

“...April 30 we’re doing a drug take-back day and that’s going to be here, it’s going to be outside under the pavilion, but hopefully with that being said that kind of kicks off these events that we can hopefully host here... by no means are we saying hundreds of people, but things like support groups and smaller events like that would be beneficial, and we can do it safely...”

### ***Addressing Social Needs and Preventative Health***

“We’ve been trying to work on some plans to have information available at outreach events so that people can get lined up with a primary care physician or have information about a primary care physician... trying to figure out how we can add value to those events so that people can get signed up for screenings who need them at the events... there’s definitely a need for people who don’t have insurance and to me, those social needs drive people to lots of these health fairs.”

Despite the epic disruption in anticipated programming caused by the COVID-19 pandemic and several staff transitions, UH Ahuja Medical Center successfully pivoted during this unprecedented circumstance to continue to engage the community and provide valuable information, support and access to COVID-19 testing and vaccination.



## Evaluation of Impact

## **Beachwood RH, LLC (University Hospitals Rehabilitation Hospital, a Joint Venture with Kindred Healthcare)**

Beachwood RH, LLC (“UH Rehabilitation Hospital”) is a 50-bed, state-of-the-art acute inpatient rehabilitation hospital located in Beachwood, Ohio. UH Rehabilitation Hospital provides acute inpatient medical and functional rehabilitation, as well as treatment and recovery services for individuals who have experienced a variety of conditions including amputation, brain injury, neurological condition, orthopedic injury, spinal cord injury, stroke, and trauma. Outpatient services for individuals with conditions that do not require inpatient rehabilitation care are available at several convenient community locations. In 2021, most (65%) of University Hospitals Rehabilitation Hospital discharges were residents of Cuyahoga County.

### **Evaluation of Impact: UH Rehabilitation Hospital Community Health Improvement Efforts**

The following evaluation of impact pertains to the actions taken since the last Cuyahoga County CHNA in 2019. The assessment was done jointly with the Cuyahoga County Board of Health, Cleveland Department of Public Health and other community partners and aligns with the State Health Assessment (SHA) and State Health Improvement Plan (SHIP). The 2019 Cuyahoga County CHNA was adopted by University Hospitals in September of 2019, and the 2020-2022 Implementation Strategy was adopted in March of 2020. This evaluation report covers the period January 2019 – December 2021. Outcomes from the 2020-2022 period will be further analyzed in early 2023, in order to include 2022 progress in total, and to further inform prospective 2023 implementation strategies.

Upon review of UH Rehabilitation Hospital’s 2019 Community Health Needs Assessment, hospital leadership isolated one priority: **Chronic disease management and prevention.**

The following objectives were established to address the above community health needs:

- Screen at least 250 individuals annually
- Increase awareness and education regarding stroke prevention and overall wellness for 500 individuals annually

### **Impact**

Between 2019 and 2021, UH Beachwood Medical Center facilitated support groups and educational sessions pertaining to stroke and brain injury to over 400 participants. Additionally, caregivers delivered healthy eating classes to 60 participants, and provided education and blood pressure, grip, and balance screenings to over 40 participants.

### **Hospital Leadership Interviews**

In order to provide a qualitative context regarding UH Beachwood Medical Center’s successes and opportunities for improvement related to the implementation strategies, a discussion guide comprised of four anchor questions was utilized to frame an interview with UH Beachwood Medical Center’s leadership and caregivers on March 31, 2022.

5. Overall, what strategies worked well since their inception, or naturally found traction within the community?
6. What strategies experienced barriers to implementation, or were unable to be implemented?
7. How did the COVID-19 pandemic impact your implementation strategies?
8. Were there new relationships that resulted from the COVID-19 pandemic response that could potentially be leveraged in the future to improve the community’s health?

As a result of these conversations, the following qualitative themes emerged: 1) Community Outreach Activities and the COVID-19 Pandemic, and 2) Amplification of complex needs stemming from the pandemic. The following quotes illustrate these themes:

***Community Outreach Activities and the COVID-19 Pandemic***

“We would like to [go back to support groups in the community], but we did not want to be the first building in the system to do so... [Trying to do support groups virtually] is just tough with that population. Our average age here is 66 and then add a stroke on... it's just been challenging even with that help of their family members for the community... it's been tough for that generation.”

***Patients with Complex Health Needs***

“...We get patients...that have very unique needs, and we obviously want to try and meet those needs as much as possible, some as small as like, people can't get a ramp built for their home as they get ready to transition home, or they don't know how to establish a PCP, or they don't know of support groups, they don't know of outpatient therapy clinics that treat their specific diagnosis...”

Despite the epic disruption in anticipated programming caused by the COVID-19 pandemic and several staff transitions, UH Beachwood Medical Center successfully pivoted during this unprecedented circumstance to continue to engage the community and provide valuable information, support and access to COVID-19 testing and vaccination.



## Evaluation of Impact

## **UH Bedford Medical Center and UH Richmond Medical Center, Campuses of UH Regional Hospitals**

During the evaluation period (January 2019 – December 2021)<sup>26</sup> UH Bedford Medical Center was a 14-bed community-based hospital, located in Bedford, OH, that provided adult emergency services, infusion, and imaging services, and a robust network of primary and specialty care physician practices to residents of Bedford and surrounding communities. UH Bedford Medical Center retained medical staff and physicians trained in 30 medical specialties, including but not limited to orthopedics, ophthalmology, wound care, neurology and hyperbaric medicine, respectively.

UH Richmond Medical Center was a 14-bed acute care hospital located in Richmond Heights, OH. UH Richmond Medical Center primarily served residents of Cuyahoga and Lake Counties, and provided adult emergency services, imaging facilities, outpatient surgery, a dedicated wound care center, and a network of primary and specialty care physician practices.

### **Evaluation of Impact: UH Bedford and Richmond Medical Centers Community Health Improvement Efforts**

The following evaluation of impact pertains to the actions taken by UH Bedford Medical Center and UH Richmond Medical Center since the last Cuyahoga County CHNA in 2019. The assessment was done jointly with the Cuyahoga County Board of Health, Cleveland Department of Public Health and other community partners and aligns with Ohio's State Health Assessment (SHA) and State Health Improvement Plan (SHIP). The 2019 Cuyahoga County CHNA was adopted by University Hospitals in September of 2019, and the 2020-2022 Implementation Strategy was adopted in March of 2020. This evaluation report covers the period January 2019 – December 2021. Outcomes from the 2020-2022 period will be further analyzed in early 2023, in order to include 2022 progress in total, and to further inform prospective 2023 implementation strategies.

Upon review of the 2019 UH Bedford and Richmond Medical Centers community health needs assessment, hospital leadership isolated two top priority community health needs:

- 1. Chronic Disease Management and Prevention**
- 2. Improve Community Conditions**

Within these areas, in consideration of UH Bedford and Richmond Medical Center's expertise and its being a community-based hospital, the following objectives were established:

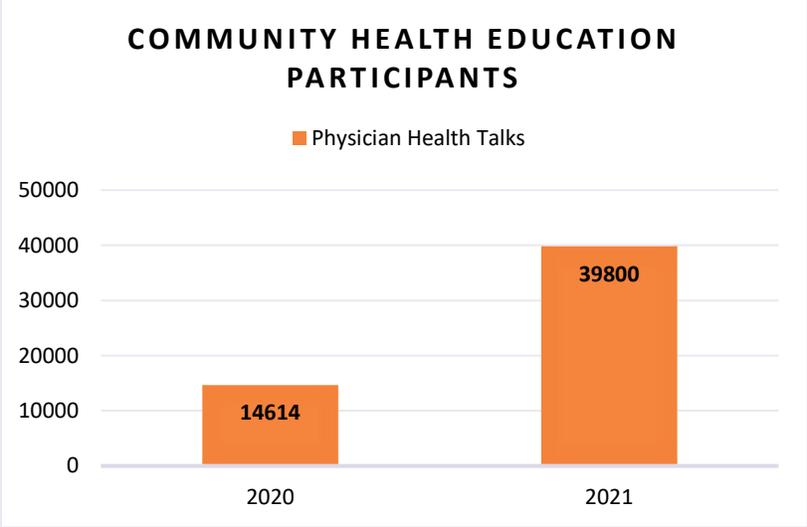
- Increase the number of people in the community screened for early detection of chronic disease by 200 screenings at each facility annually
- Increase awareness and education of chronic disease prevention and management by 250 individuals at each facility annually
- Discuss and distribute information to at least 200 community members at each hospital facility regarding appropriate options for hospital utilization and financial counseling services available

### **Impact**

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<sup>26</sup> UH Bedford Medical Center and UH Richmond Medical Center discontinued inpatient, surgical and emergency services on August 12, 2022. Community programming will continue in these communities despite this occurrence.

In 2019, UH Bedford Medical Center and UH Richmond Medical Center provided chronic disease detection and management education to 700 community residents, while also administering 1,793 chronic disease screenings, and educating more than 250 community residents regarding the availability of financial assistance. Between 2020 and 2021, UH Bedford Medical Center and UH Richmond Medical Center hosted a total of 20 physician-led virtual education events reflecting 13 medical departments and specialties, including but not limited to surgery, urology, respiratory and heart health, diabetes, women’s health, neurology, gastroenterology, emergency medicine, and otolaryngology. The respective virtual education events, which were facilitated by the pastor of Mt. Zion Church in Oakwood Village, attracted a total of 14,614 participants in 2020, and 39,800 participants in 2021. These sessions were also recorded and subsequently posted on the Mt. Zion Oakwood Village YouTube channel to ensure for broader community dissemination.



UH Bedford Medical Center and UH Richmond Medical Center also provided wellness education materials to 2,353 patients upon discharge throughout 2020, and to 5,971 patients in 2021. Materials outlining appropriate utilization of hospital utilization and the availability of financial counseling options were distributed to 1,303 UH Bedford and UH Richmond Medical Center patients in 2020, and to 3,329 patients in 2021. Collectively, the hospitals provided more than 1,400 free health screenings to individuals with healthcare access barriers, reached 8,578 participants by way of the Family Health and Safety Days events between 2020 and 2021.

In response to the COVID-19 pandemic, UH Bedford Medical Center and UH Richmond Medical Center provided more than 50 hours of staff time to support COVID-19 screening activities conducted in the Wickliffe, Willoughby, and Richmond Heights communities, respectively.

### Hospital Leadership Interviews

In order to provide a qualitative context regarding UH Bedford Medical Center and UH Richmond Medical Center’s successes and opportunities for improvement related to the implementation strategies, a discussion guide comprised of four anchor questions was utilized to frame an interview with UH Bedford Medical Center and UH Richmond Medical Center leadership staff on April 5, 2022:

1. Overall, what strategies worked well since their inception, or naturally found traction within the community?
2. What strategies experienced barriers to implementation, or were unable to be implemented?
3. How did the COVID-19 pandemic impact your implementation strategies?

4. Were there new relationships that resulted from the COVID-19 pandemic response that could potentially be leveraged in the future to improve the community's health?

As a result of these conversations, the following qualitative themes emerged pertaining to UH Regionals' community health implementation strategy from 2019-2021: 1) Collaboration with the faith-based community, and 2) Impact of the COVID-19 pandemic. The following quotes illustrate these themes:

#### ***Collaboration with the Faith-based Community***

"Our healthy talks with [the pastor], we really reached a lot of people; he had a huge audience to help us impact our community, that was shared with over a hundred...congregations across Northeast Ohio, in addition to the 6,000 people that are a part of Mt. Zion congregation, so we had some big numbers."

"A lot of our patients, who I would refer to as super-users, are older adults and they attend church; they are very connected to their congregations, so we've done a lot of things with many of the congregations around our two hospitals."

#### ***Impact of the COVID-19 Pandemic***

"It really impacted our ability to reach our audience, which is why the virtual (programming) really helped us a lot. The senior centers closed, the congregations, that was all virtual for the most part...our education was all virtual, any screenings that we did were, our preventative screens we couldn't do, you know, the typical things like blood pressures and things that could indicate some issues, everything had to be virtual, so it greatly impacted us."

"...we definitely got closer, our relationships stronger with Willoughby Hills, Wickliffe, Richmond Heights, Oakwood, our local communities...Maple Heights."

Despite the epic disruption in anticipated programming caused by the COVID-19 pandemic, UH Bedford Medical Center and UH Richmond Medical Center successfully pivoted during this unprecedented circumstance to continue to engage the community and provide valuable information, support and access to COVID-19 vaccination.



## Evaluation of Impact

## University Hospitals Cleveland Medical Center

UH Cleveland Medical Center is a 1,032 bed, academic medical center and an affiliate of Case Western Reserve University. It is located on a 35-acre campus in the University Circle neighborhood of Cleveland, OH which includes University Hospitals Rainbow Babies & Children's Hospital and University Hospitals Seidman Cancer Center. UH Cleveland Medical Center provides comprehensive medical care including emergency, surgical and cancer care. Its physicians and researchers are also engaged in a wide spectrum of translational-, clinical-, and population-focused research, with more than 2,900 active trials and a research portfolio amounting to \$177 million. In 2021, most (58%) of University Hospitals Cleveland Medical Center's discharges were residents of Cuyahoga County.

### Evaluation of Impact: UH Cleveland Medical Center Community Health Improvement Efforts

The following evaluation of impact pertains to the actions taken by UH Cleveland Medical Center since the last Cuyahoga County CHNA in 2019. The assessment was done jointly with the Cuyahoga County Board of Health, Cleveland Department of Public Health and other community partners and aligns with Ohio's State Health Assessment (SHA) and State Health Improvement Plan (SHIP). The 2019 Cuyahoga County CHNA was adopted by University Hospitals in September of 2019, and the 2020-2022 Implementation Strategy was adopted in March of 2020. This evaluation report covers the period January 2019 – December 2021. Outcomes from the 2020-2022 period will be further analyzed in early 2023, in order to include 2022 progress in total, and to further inform prospective 2023 implementation strategies.

Upon review of the 2019 UH Cleveland Medical Center Community Health Needs Assessment, leadership isolated four top priority community health needs:

- 1. Chronic Disease Management and Prevention**
- 2. Improve Community Conditions**
- 3. Mental Health and Addiction**
- 4. Eliminating Structural Racism**

The following objectives were established to address the priorities outlined in the 2019 UH Cleveland Medical Center Community Health Needs Assessment:

- Increase calcium score screening
- Increase reach with under-resourced populations
- Increase knowledge of patients and community members regarding prevention of heart disease and/or management of chronic disease for diagnosed individuals
- Provide education and screenings to 750 participants
- Host and/or participate in 12 cancer-related educational screening events
- Improve accessibility of cancer screening and education in targeted high-risk populations
- Increase the number of students who are prepared to respond in the event of traumatic injuries at school
- Increase the number of individuals who know Cardiopulmonary Resuscitation (CPR) and how to use an Automated External Defibrillator (AED) machine
- Reduce food insecurity and prevent chronic disease and/or disease progression for under-resourced patients
- Increase access to care for African American men
- Assist patients with navigating systems of care to attain necessary social service
- Provide community space for job training, wellness classes, and support groups

- Following violent incidents, connect all eligible patients to mediation, conflict resolution and case management services, while hospitalized and referral to necessary social services upon discharge
- Increase knowledge about the risks and resources available to prevent or treat substance addiction
- Raise an awareness about proper prescription drug disposal
- Prepare the future workforce for careers in behavioral health science
- Equip 45 students with the necessary post-secondary education/training to prepare them for careers as physicians

## **Impact**

In 2019, UH Cleveland Medical Center provided a variety of offerings across its enterprise including:

### **Harrington Heart & Vascular Institute**

- 5,348 individuals received free calcium score testing
- 750 community residents were taught to recognize stroke symptoms and risk factors
- 1,053 community residents benefitted from screenings related to early detection of cardiovascular disease
- 1,225 individuals were educated regarding prevention and risk factors for cardiovascular disease
- 1,565 individuals benefitted from trainings in local schools and businesses on cardiac arrest and heart failure education and risks
- 500 local students learned about health professions and healthy lifestyles

### **Seidman Cancer Center**

- 729 individuals benefitted from Cancer-related education and screenings.

### **Violence Interrupters**

- 101 eligible patients were informed of social supports and services available to address needs behind their immediate trauma-related incident.

Between 2020 and 2021, UH Cleveland Medical Center provided the following community health services:

### **Harrington Heart & Vascular Institute**

- 11,431 individuals received free calcium score testing
- 6,213 community residents received education regarding cardiovascular disease and cardiovascular risk factors and nearly 800 were screened for cardiovascular disease.
- 5,219 community members and first responders were trained in cardiopulmonary resuscitation (CPR) and utilization of an automated external defibrillator (AED)
- 2,100 local Cuyahoga County students were trained on how to assist a bleeding victim in an emergency situation via the Stop the Bleed program.

### **Violence Interrupters**

- 280 individuals were assisted by social workers regarding gun-related incidents, 138 of whom received additional services from social service agencies via referrals, to address issues such as education and job placement.

## Otis Moss Center

- 3,068 eligible patients received food from Otis Moss Center's Food for Life Market.
- 47 individuals participated in workforce programming, including job and skills training
- The following objectives were unable to be met due to several caregiver transitions during the COVID-19 pandemic:
  - Increase access to care for African-American men
  - Assist patients with navigating systems of care to attain necessary social services

## Health Scholars Program

- 18 individuals, representing 95% of eligible students, completed the UH Health Scholars program and successfully enrolled in an undergraduate pre-medicine program. This program is designed to increase the number of physicians from minoritized populations.

## COVID-19 Efforts

In response to the COVID-19 pandemic, in March 2020 UH Cleveland Medical Center partnered with the Cleveland Clinic to initiate one of the nation's first drive-through COVID-19 testing sites. Later in the year, UH introduced Ohio's first mobile COVID-19 testing unit. Beginning in December 2020, the hospital began a vaccination campaign for its caregivers to protect against COVID-19. Between December 2020 and December 2021, the hospital administered 57,486 vaccinations, representing 28,743 caregivers. In 2021, UH Cleveland Medical Center expanded vaccination to the general public and administered 122,388 no-cost COVID-19 vaccinations for community members. Further, in 2021, UH Cleveland Medical Center performed COVID-19 testing for 372,092 community members. In collaboration with the Army National Guard and the Cleveland Clinic, the hospital organized a centralized testing site in late 2021 to provide rapid COVID-19 testing to community members to meet the demand for testing due to the persisting pandemic. Finally, University Hospitals created and disseminated the [UH Healthy Restart Playbook](#) in order to provide a trustworthy resource for community organizations to protect and take care of their workforce, facilities, and customers.

## Hospital Leadership Interviews

In order to provide a qualitative context regarding UH Cleveland Medical Center's successes and opportunities for improvement related to the implementation strategies, a discussion guide comprised of four anchor questions was utilized to frame an interview with hospital leadership staff on April 7, 2022:

5. Overall, what strategies worked well since their inception, or naturally found traction within the community?
6. What strategies experienced barriers to implementation, or were unable to be implemented?
7. How did the COVID-19 pandemic impact your implementation strategies?
8. Were there new relationships that resulted from the COVID-19 pandemic response that could potentially be leveraged in the future to improve the community's health?

As a result of these conversations, the following qualitative themes emerged pertaining to UH Cleveland Medical Center's community health implementation strategy from 2019-2021: 1) investment in community programming, 2) the impact of the COVID-19 pandemic, and 3) the Violence Interrupter program. The following quotes illustrate these themes:

### ***Investment and Commitment in Community Programming***

“...nobody knows the longevity of these (other youth career pipeline) programs, the sense is they’re going to dry out when the funding dries out. UH’s is unique in that we are self-funded, so for better or for worse, we are not going out asking for philanthropic funds, we are investing in this pathway, and when we look at our most recent graduates, for example, there are 19 of them, 18 of whom went to college; that 19 will be going to college in the Fall...”

“...speaking to the issue of trust, I think that we have kind of an established relationship with communities, CMSD (Cleveland Metropolitan School District), Shaker, Cleveland Heights, etc., and I think we are moving the needle, although in a very anecdotal way...”

“...we did a lot of community outreach there (Cleveland Metropolitan Housing Authority) ... it’s a little challenging just to get residents engaged, but once you have them engaged and build their trust then its fine. When we first went, it was like literally dragging them out of their apartments to get them to come to anything, we started with like two or three, and then it was like four or five, and then it was like ten...it was challenging in the beginning, but once we built that trust, then it was good. It was a really rewarding experience for me...”

### ***The Impact of the COVID-19 Pandemic***

“Due to COVID-19, many outreach activities involving meeting in-person were halted. In-person activities were changed to virtual activities...from the cancer perspective, pre-COVID, I think we had a considerable amount of outreach events that resulted in health screenings and that’s wonderful, we have a mobile mammogram van that goes out and does those screenings but during COVID, at least during the first quarter of that first year, all cancer screenings came to a complete halt, including inside UH, so no colonoscopies, no mammograms, and that was really, really hard to recover from, so luckily we have been able to get those back in order but we are starting to see that folks who were hesitant to get screened were even more hesitant during COVID, and they still haven’t come back in the same numbers...”

“Educating the community was challenging during the pandemic...there needed to be a period of reengagement to establish relationships. COVID had taken so much of the time and energy around public health, often cancer education and screenings were not top of list to address.”

“...a lot of our outreach was done in schools, and when schools were shut down or virtual we couldn’t do a lot of the screening or education we have done (previously), especially when it came to CPR and AED training, and we did a lot of education in the schools that we weren’t able to do, and virtually, it was hard to do a lot of what we were doing”

“...for COVID, we pivoted from being an in-person (Health Scholars) program to an online program, and one of the benefits of that is that...it kept kids in their homes and not out in the streets during a highly communicable time, a COVID communicable time, so we thought that was a benefit but the other is that we were able to get kids into the program who wouldn’t have been able to get to CMC (Cleveland Medical Center) on a regular basis, in a regular way, on time, and fully participatory, and so there were a lot of challenges with COVID, but there were also a lot of opportunities...”

“...for components of the (Health Scholars) program we farmed it out to experts, so we did not purport to be experts in mindfulness or any of the other things we have done, so we did establish partnerships with Zen Works Yoga, we established partnerships with New Bridge, we established partnerships internally with different clinical departments, we established partnerships with the library...we have a library here, and our librarian has been fantastic, and kind of helping our students navigate different readings...and so we say COVID, and again we were

in a unique position, but we saw COVID as a series of opportunities to expand and build and make better our program, and I am grateful for that...”

### ***Violence Interrupter Program***

“I really think it shifted in 2019, and I think a lot of it was groundwork that was just ... we made sure that Violence Interrupters met everybody in the ICU, the ICU Nursing staff, they met the floor nursing staff, we had them go to two or three shift meetings where they met everybody from Protective Services...and I really think it only took a while. The nursing staff was actually quite happy with having the Violence Interrupters around to intervene, because, you know, it’s not what the nurses do, it’s not what the physicians do, it’s out of our realm when you’re talking to someone about gang violence...”

Despite the epic disruption in anticipated programming caused by the COVID-19 pandemic, UH Cleveland Medical Center successfully pivoted during this unprecedented circumstance to continue to engage the community and provide vaccination, testing, and valuable information and support as it relates to COVID-19.



## Evaluation of Impact

## University Hospitals Parma Medical Center

UH Parma Medical Center is a 287-bed community-based hospital located in Parma, OH that provides acute and subacute care to residents of Parma, Brooklyn, Seven Hills, North Royalton, and neighboring communities. With more than 800 physicians across 30 specialties, UH Parma Medical Center retains experts specializing in stroke, cardiac care, cancer, orthopedics, pain management, acute rehabilitation, and bariatric care, and has received national accolades for both orthopedic and cardiovascular outcomes. UH Parma Medical Center also provides radiology, diagnostic imaging, physical therapy, laboratory, home healthcare, hospice, and screening and educational services, respectively. In 2021, most (87%) of University Hospitals Parma Medical Center's discharges were residents of Cuyahoga County.

### Evaluation of Impact: UH Parma Community Health Improvement Efforts

The following evaluation of impact pertains to the actions taken by UH Parma Medical Center since the last Cuyahoga County CHNA in 2019. The assessment was done jointly with the Cuyahoga County Board of Health, Cleveland Department of Public Health and other community partners and aligns with the State Health Assessment (SHA) and State Health Improvement Plan (SHIP). The 2019 Cuyahoga County CHNA was adopted by University Hospitals in September of 2019, and the 2020-2022 Implementation Strategy was adopted in March of 2020. This evaluation report covers the period January 2019 – December 2021. Outcomes from the 2020-2022 period will be further analyzed in early 2023, in order to include 2022 progress in total, and to further inform prospective 2023 implementation strategies.

Upon review of the 2019 UH Parma Medical Center Community Health Needs Assessment, hospital leadership isolated two top priority community health needs:

- 1. Improve community conditions**
- 2. Reduce chronic illness and its effects**

After pinpointing the top priorities, strategies and tactics were created, lending the hospital's staff expertise and resources to combatting each community health issue. Objectives are outlined below:

- Detect early signs of chronic diseases in an effort to prevent or mitigate disease progression
- Increase awareness and education of chronic disease prevention and management to improve health literacy and health outcomes
- Increase access to healthy meals by providing home-delivered meals to senior citizens in partnership with Meals on Wheels, and lunch to children while visiting UH Parma Medical Center

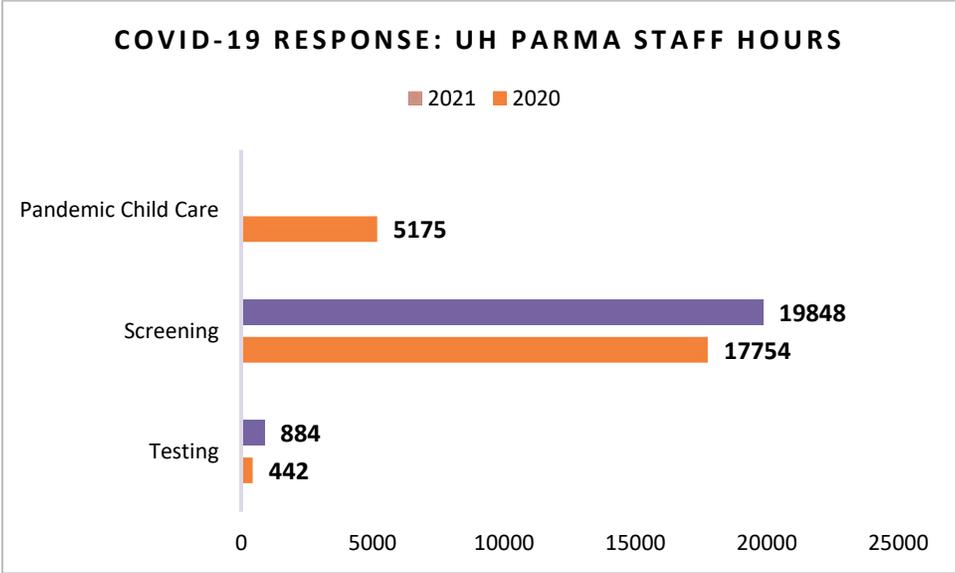
### Impact

In 2019, UH Parma Medical Center provided a total of 8,057 biometric screenings at community events and senior centers, and promoted healthy lifestyle choices to 2,123 individuals participating in wellness programs, yoga classes, support groups, and Parkinson's exercise and smoking cessation programs, respectively. Screening outreach events reached a total of 290 community residents on-site and in the community in 2019, while 2,284 meals were provided to adults via Meals on Wheels and children through the USDA Summer Lunch Program to address food insecurities.

Between 2020 and 2021, UH Parma Medical Center provided 1,715 community-based biometric screenings addressing its priority focused on reducing chronic illness and made referrals when applicable. Additionally, it offered programming to promote healthy lifestyle choices and structured exercise programs to 748 and 410 community residents, respectively. Health education mailers were distributed regularly over this time period, totaling 104,000 touches and nearly 2,000 meals were provided to residents of Seven Hills and Parma Heights by

way of the Meals on Wheels program, and to children through the USDA Summer Lunch Program in partnership with Sodexo.

In response to the COVID-19 pandemic, UH Parma Medical Center staffed COVID-19 screening stations across seven locations in 2020 and four locations throughout 2021, requiring nearly 18,000 staff hours in 2020, and 20,000 caregiver hours in 2021. UH Parma Medical Center supported COVID-19 testing sites from July of 2020 through December of 2021, requiring a total of 1,326 caregiver hours. Moreover, UH Parma Medical Center obtained a pandemic childcare license in early 2020, and operated under this license through May of 2020 to support the childcare needs of UH Parma Medical Center employees, physicians, and Parma community residents, the latter of which was supported by 5,175 staff hours.



### Hospital Leadership Interviews

In order to provide a qualitative context regarding UH Parma Medical Center’s successes and opportunities for improvement related to the implementation strategies, a discussion guide comprised of four anchor questions was utilized to frame an interview with UH Parma Medical Center leadership and caregivers on April 12, 2022:

1. Overall, what strategies worked well since their inception, or naturally found traction within the community?
2. What strategies experienced barriers to implementation, or were unable to be implemented?
3. How did the COVID-19 pandemic impact your implementation strategies?
4. Were there new relationships that resulted from the COVID-19 pandemic response that could potentially be leveraged in the future to improve the community’s health?

As a result of these conversations, the following qualitative themes emerged pertaining to UH Parma Medical Center’s community health implementation strategy from 2019-2021: 1) The Value of Virtual Health Education, 2) Community leadership during the COVID-19 pandemic, and 3) Availability and need for mental health services. The following quotes illustrate these themes:

#### *The Value of Virtual Health Education*

“The marketing department implemented the healthy [physician] presentations...so everything was virtual... I don’t know if we’ll ever go back to in-person physician presentations because the attendance at these far exceeded what we have ever really gotten when we do an in-person talk. I think people are comfortable doing it

from their home and it's just more convenient, so we leveraged that and took all of those topics, whether it was diabetes or sleep, or if it was on the pandemic, and we would take our database of our community partners and we would make sure that they had that information to share with their members."

### ***Community Leadership during the COVID-19 Pandemic***

"...the Healthy UH Playbook for COVID and the Restart Playbook for businesses, we utilized that quite a bit, and we would hold meetings with our mayors and with our school superintendents and some of our local businesses, and we would walk through those playbooks with them too, so another great trust initiative..."

"...they [community relationships] were strengthened, definitely, because a lot of our community leaders, again whether it was the mayors, the superintendents, the fire chiefs, they were looking to us for help and guidance, and we were able to provide that to them, we were their go-to...and we hear a lot, 'thank you, thank you for what you did, thank you for your education, providing us with PPE', and things like that..."

"...I think it was such a unique time, and you don't forget things like that, you don't forget when you're in the throes of a crisis who was standing next to you..."

### ***Availability and Need for Mental Health Services***

"...we have gotten in the last month I think three requests from different school districts for mental health, more mental health access, and so in talking with various folks in our behavioral health...access is a huge issue, and they acknowledge it..."

Despite the epic disruption in anticipated programming caused by the COVID-19 pandemic, UH Parma Medical Center successfully pivoted during this unprecedented circumstance to continue to engage the community and provide valuable information, support and access to COVID-19 testing and vaccination.



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## Evaluation of Impact

## University Hospitals Rainbow Babies & Children's Hospital

University Hospitals Rainbow Babies & Children's is a 244-bed full-service children's hospital and academic medical center located in Cleveland, OH. With access to more than 1,300 pediatric specialists, advanced treatments, and pediatric care innovations, and providing specialized care to infants, children, teens, and young adults less than 21 years of age, UH Rainbow Babies & Children's provides a complete range of care for upwards of 750,000 patient encounters each year, and is among the largest pediatric care providers in the state of Ohio. In 2021, most (54%) of UH Rainbow Babies & Children's discharges were residents of Cuyahoga County.

### Evaluation of Impact: UH Rainbow Babies & Children's Community Health Improvement Efforts

The following evaluation of impact pertains to the actions taken by UH Rainbow Babies & Children's since the last Cuyahoga County CHNA in 2019. The assessment was done jointly with the Cuyahoga County Board of Health, Cleveland Department of Public Health and other community partners and aligns with Ohio's State Health Assessment (SHA) and State Health Improvement Plan (SHIP). The 2019 Cuyahoga County CHNA was adopted by University Hospitals in September of 2019, and the 2020-2022 Implementation Strategy was adopted in March of 2020. This evaluation report covers the period January 2019 – December 2021. Outcomes from the 2020-2022 period will be further analyzed in early 2023, in order to include 2022 progress in total, and to further inform prospective 2023 implementation strategies.

Review of the 2019 UH Rainbow Babies & Children's community health needs assessment enabled the hospital to isolate two top priority community pediatric health needs:

- 1. Improve Community Conditions**
- 2. Eliminate Structural Racism**

After pinpointing the top priorities, action plans were created, lending hospital staff expertise and resources to combatting the more vexing health issues facing families in our community. Objectives are outlined below:

- Reach at least 2,000 underserved children each year, throughout a 20-county area to provide routine dental screenings, cleanings, and preventative care
- Reduce the number of children with UH Emergency Department visits due to dental issues to less than five patients per week
- Increase the number of patients screened for food insecurity
- Implement programs to educate families on proper nutrition and healthy recipes
- Provide healthy meals to children in the summer and on weekends
- Reduce racial disparities regarding food insecurity
- Decrease the number of infant deaths and racial disparities
- Decrease pre-term deliveries and low birthweight infants
- Increase breastfeeding

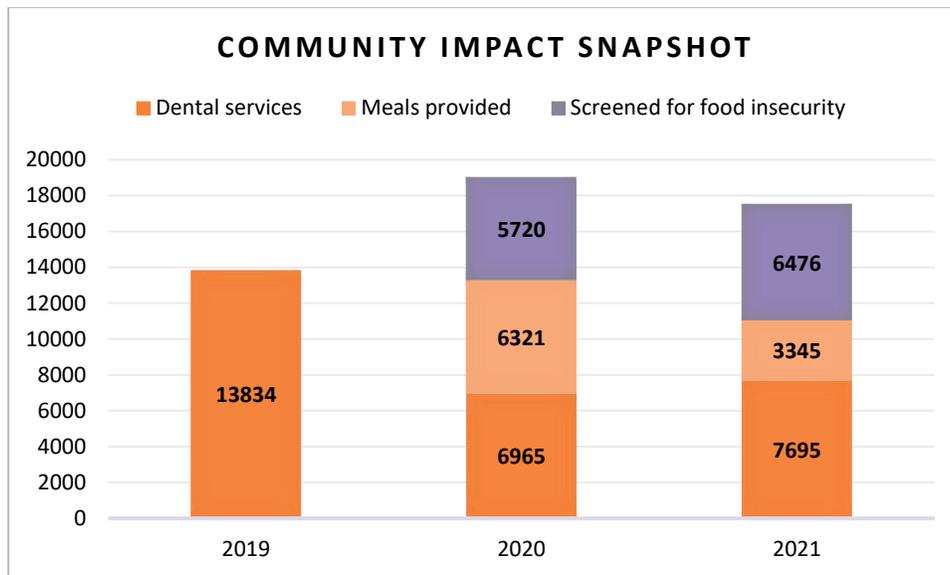
**Impact**

In 2019, UH Rainbow Babies & Children’s provided dental services to 11,733 underserved pediatric dental patients, and to 2,101 patients with the mobile dental unit. Between 2020 and 2021, UH Rainbow provided preventative care, sealants, fluoride treatments, dental caries, and dental treatment options such as filling cavities, extractions, pulp therapy, and crown placement to nearly 14,000 children between the ages of three and 12, and 1,028 children were provided this care in their respective communities by way of a mobile care unit. UH Rainbow Babies & Children’s aims to increase access to pediatric preventative dental care and reduce emergency department utilization; however, currently data are not readily accessible to measure this outcome.

In 2019, the hospital also served more than 1,100 patients by way of the Healthy Harvest produce distribution program. Moreover, a total of 9,666 meals were provided to children throughout the community via the summer lunch program, 12,196 patients were screened for food insecurity and assisted in obtaining necessary resources, and weekly cooking demonstrations were provided to 4,714 participants through the Healthy Harvest program between 2020 and 2021.

<b>Centering Pregnancy Outcomes</b>					
<b>Year</b>	<b>Preterm Births</b>	<b>Low Birth Weight</b>	<b>Breastfeeding at Discharge</b>	<b>Total births</b>	<b>Centering Enrollment</b>
<b>2019</b>	6.7%	8.1%	79%	294	472
<b>2020</b>	6.6%	10%	71%	141	150
<b>2021</b>	7.6%	6%	71%	132	255

In 2019, UH Rainbow Babies & Children’s enrolled 472 women in the Centering Pregnancy program, which provides education related to breastfeeding, infant mortality, safe sleep, food-based learning activities, and recipe demonstrations, as well as strategies to reduce maternal stress and depression. A total of 405 expecting mothers were also enrolled in the Centering Pregnancy program in 2020 and 2021. As a result of the Centering Pregnancy program and related UH Rainbow Babies and Children’s Hospital initiatives, 79% of new mothers were breastfeeding at the time of discharge, and 71% of new mothers were breastfeeding upon discharge in 2020 and 2021. Infants with low birth weight declined from 8.1% in 2019 to 6% in 2021. Finally, appointment compliance for the Centering Pregnancy program increased from 71% in 2019 to 76% and 81% in 2020 and 2021, respectively.



In response to the COVID-19 pandemic, UH Rainbow Babies & Children’s Hospital convened a multidisciplinary contingency planning team to identify and support additional stresses and strains for families as a result of the pandemic. As a result, the UH Rainbow Connects team initiated a new system to stratify patient needs, urgency, engagement, and activation, in order to prioritize navigation and follow-up. Additionally, the Rainbow Connects team reconfigured existing workspace into a temporary family resource center, in order to fulfill immediate patient needs pertaining to food, clothing, shoes, diapers, and other items. As a result, more than 14,000 items were distributed in 2021. The Rainbow Connects team also established computer stations to assist patients with resource navigation, benefit enrollment, and employment-related needs. As the pandemic ensues, the Rainbow Connects team has continued to revise and update resource guides accordingly, and actively communicate available resources onsite and throughout the community.

### Hospital Staff Interviews

In order to provide a qualitative context regarding UH Rainbow Babies & Children’s successes and opportunities for improvement related to the implementation strategies, a discussion guide comprised of four anchor questions was utilized to frame an interview with UH Rainbow staff and caregivers on March 23, 2022:

1. Overall, what strategies worked well since their inception, or naturally found traction within the community?
2. What strategies experienced barriers to implementation, or were unable to be implemented?
3. How did the COVID-19 pandemic impact your implementation strategies?
4. Were there new relationships that resulted from the COVID-19 pandemic response that could potentially be leveraged in the future to improve the community’s health?

As a result of these conversations, the following qualitative themes emerged pertaining to UH Rainbow Babies & Children’s community health implementation strategy from 2019-2021: 1) Equitable access to improve maternal health services, 2) The impact of the COVID-19 pandemic, and 3) Opportunity to streamline resource navigation. The following quotes illustrate these themes:

### ***Equitable Access to Improve Maternal Health Services***

“What was impactful for us was just the personal relationships. We called them [patients] in between appointments, we stayed connected through video chats and things like that, and there were some that we had to personally take under our wing, like we literally adopted a few patients, and we even worked with them on the weekends if we had to...”

“...when we are in centering for pregnancy we actually go back historically when it comes to breastfeeding because we like to get to the root as to, if a mom does not want to, why? And we help to dispel some of those myths, and if it’s an issue where maybe there was, we find that there was sexual trauma in their history, and they have a hard time separating that, and that’s where (name omitted) comes in, our maternal mental health therapist, she works with them on that part, and we can get them breastfeeding. So that’s part of the reason that it’s much better; we are dealing with the root cause as to why they’re hesitant...”

“We’ve had lactation consultants from CMC, from the labor and delivery unit actually come in here and say ‘what are you all doing’, specifically with Black women, and why are so many of these women coming in and they’re educated and they know exactly what they want; they may not show us an on-paper birth plan, but it’s like they don’t even need our help, and that means so much, especially as there is study after study that has come out that have proven that lactation consultants don’t even go into the rooms of Black women at all because they just assume that Black women are not breastfeeding...so to see the lactation consultants coming in here and saying hey, these particular Black women not only know what they want when they walk in but they are also educating other women while they’re there, and being a champion for breastfeeding, is absolutely amazing...”

### ***The Impact of the COVID-19 Pandemic***

“...with COVID, it had to become more personalized, and we just had to focus on those who had more severe needs and more severe social and economic things going on...so we just had to build a relationship, we had to make them our sisters, make them our daughters, for a short period of time, and that was just it, we just had to go back to those times when we were in their shoes, and give them what we needed at that time, and those things that we didn’t get...”

“I have to say that COVID has actually helped us with our breastfeeding advocacy, because we are framing it as if that is the baby’s first immunization, and it actually truly is, so we let them know if you are concerned about COVID and these things, this is one of the best things you can do to help you and your baby...it’s something about correlating that with COVID, for whatever reason, the moms actually respond very well to that...”

“...Looking at it from outside of the Rainbow center, when I look at other community health worker organizations, they shut down...all of these organizations who are usually out on the forefront, a lot of them were working from home...to see (names omitted) going to people’s homes in the midst of COVID, when everyone else was running away from the fire, they were like running straight into it, and I think it really made a difference because our patients didn’t want that virtual touch”

“...we began a very fruitful, I think especially in the future, partnership with MedWish, which is a local organization dedicated to providing healthcare services to vulnerable, under-resourced, and those without medical homes or insurance, and very very early on as we were looking for support for our patients, especially those who might need to be quarantined for a bit because they have been exposed to or did have COVID, MedWish came on and provided funding for these boxes that we did for patients who might have to stay away

from the community for a while because they had been exposed to COVID, or had had someone diagnosed in the home, or were diagnosed themselves...”

***Opportunity to Streamline Resource Navigation***

“We are resource rich and coordination poor, and we don’t take that for granted, but when we go out to other places, like other counties specifically in Northeast Ohio, we realize how resource poor they are, and they struggle...but we don’t struggle with that, we just struggle on how to kind of streamline the process and connect with each other in an impactful way.”

Despite the epic disruption in anticipated programming caused by the COVID-19 pandemic, UH Rainbow Babies and Children’s Hospital successfully pivoted during this unprecedented circumstance to continue to engage the community and provide valuable information and support, as well as provide resources to address families’ social needs.



## Evaluation of Impact

## University Hospitals St. John Medical Center

UH St. John Medical Center is a 204-bed community-based hospital located in Westlake, OH that provides comprehensive medical and surgical care for children and adults residing in western Cuyahoga County and eastern Lorain County. In conjunction with an onsite diagnostic imaging and laboratory services centers, UH St. John Medical Center retains a 24/7 emergency room, as well as urology, orthopedic, and neurology care services, and a family birthing center. In 2021, most (54%) of University Hospitals St. John Medical Center's discharges were residents of Cuyahoga County.

### Evaluation of Impact: UH St. John Community Health Improvement Efforts

The following evaluation of impact pertains to the actions taken by UH St. John Medical Center UH since the last Cuyahoga County CHNA in 2019. The assessment was done jointly with the Cuyahoga County Board of Health, Cleveland Department of Public Health and other community partners and aligns with the State Health Assessment (SHA) and State Health Improvement Plan (SHIP). The 2019 Cuyahoga County CHNA was adopted by University Hospitals in September of 2019, and the 2020-2022 Implementation Strategy was adopted in March of 2020. This evaluation report covers the period January 2019 – December 2021. Outcomes from the 2020-2022 period will be further analyzed in early 2023, in order to include 2022 progress in total, and to further inform prospective 2023 implementation strategies.

Upon review of the 2019 UH St. John Medical Center community health needs assessment, hospital leadership isolated two top priority community health needs:

1. **Chronic disease management and prevention**
2. **Enhance trust**

After pinpointing the top priorities, hospital staff outlined the following objectives to address each health issue:

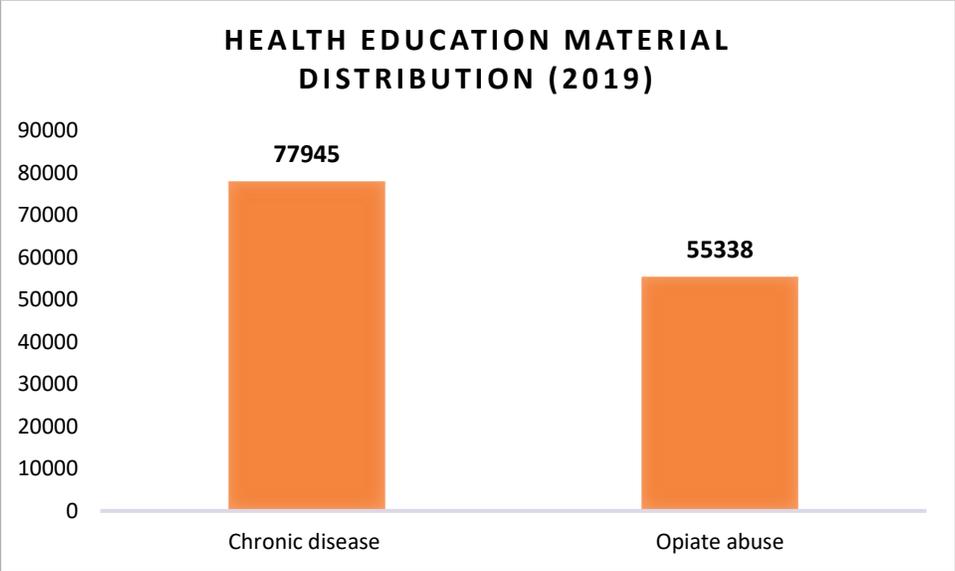
- Screen at least 1,000 individuals annually for chronic disease
- Promote healthy lifestyle choices to at least 1,000 individuals annually through exercise programs, weight-loss programs, and nutrition education
- Increase awareness and education of chronic disease self-management skills to 1,500 individuals annually
- Build relationships with at least three new organizations annually
- Continue to foster and strengthen existing relationships

### Impact

In 2019, UH St. John Medical Center screened upwards of 6,347 community residents for the presence of a chronic disease, while also collectively distributing information both in-person and via mailers to 77,945 community residents in order to raise awareness of and provide education related to chronic disease self-management skills. UH St. John Medical Center also provided education regarding the scope and course of community opiate abuse by way of community mailers, targeted community engagement, and community events, and concurrently promoted a healthy lifestyle choice campaign to 2,889 individuals across other concurrent hospital programs.

Between 2020 and 2021, UH St. John Medical Center hosted school-based workshops regarding hand-washing safety for illness control and smoking/vaping cessation to 1,532 school-aged participants, and provided 2,449 free community-based chronic disease screenings at faith-based organizations, senior centers, and community

centers. In 2021, and in addition to the free community-based chronic disease screenings, UH St. John Medical Center also participated in community-related health events including but not limited to first-aid, chronic disease self-management, exercising for the management of heart disease and diabetes, CPR, diabetes risk assessment, cancer awareness, nutrition, stress education, fall/trauma, vascular, balance, and stroke risk assessments.



In response to the COVID-19 pandemic, UH St. John Medical Center hosted three community vaccination events in December of 2020, as well as January and November of 2021, in order to provide COVID-19 vaccinations to community residents. The three clinics required nearly 400 hours of staff time.

**Hospital Leadership Interviews**

In order to provide a qualitative context regarding UH St. John Medical Center’s successes and opportunities for improvement related to the implementation strategies, a discussion guide comprised of four anchor questions was utilized to frame an interview with UH St. John Medical Center leadership and caregivers on April 7, 2022.

- 5. Overall, what strategies worked well since their inception, or naturally found traction within the community?
- 6. What strategies experienced barriers to implementation, or were unable to be implemented?
- 7. How did the COVID-19 pandemic impact your implementation strategies?
- 8. Were there new relationships that resulted from the COVID-19 pandemic response that could potentially be leveraged in the future to improve the community’s health?

As a result of these conversations, the following qualitative themes emerged pertaining to UH St. John Medical Center’s community health implementation strategy for the period 2019-2021: 1) A focus on community screenings, 2) Responding to the COVID-19 pandemic, and 3) Enhancing community trust. The following quotes illustrate these themes:

### ***A Focus on Community Screenings***

“...we were busting on our screenings out in the community...we had many health fairs, we had worked with a lot of the senior centers...our safety day was the highest attended in the system, so we take pride in that...”

### ***Responding to the COVID-19 Pandemic***

“We had them call in weekly, ‘hey, where here for you, what do you need, can we help you with anything’, information about what is going on at the hospital, because they (nursing homes) weren’t allowed to come in at this point...”

### ***Enhancing Community Trust***

“...one of the big things, you know I have my own ways of looking at things, but we’ve done a lot as far as building trust in even our own hospitals, so I’m working with (name omitted) and (name omitted) in Parma, and of course we are over in Elyria, in doing some west side events, to where it is going to be a collaboration to build trust in all of the UH west side hospitals, and then also...we are actually doing a program with Cleveland Clinic and Mercy to show trust in the community, that the three hospital systems can work together, and it’s around a cancer initiative...”

Despite the epic disruption in anticipated programming caused by the COVID-19 pandemic and several staff transitions, UH St. John Medical Center successfully pivoted during this unprecedented circumstance to continue to engage the community and provide valuable information, support and access to COVID-19 testing and vaccination.

# Appendix B. Secondary Data Methodology and Scoring Tables

## Secondary Data Sources

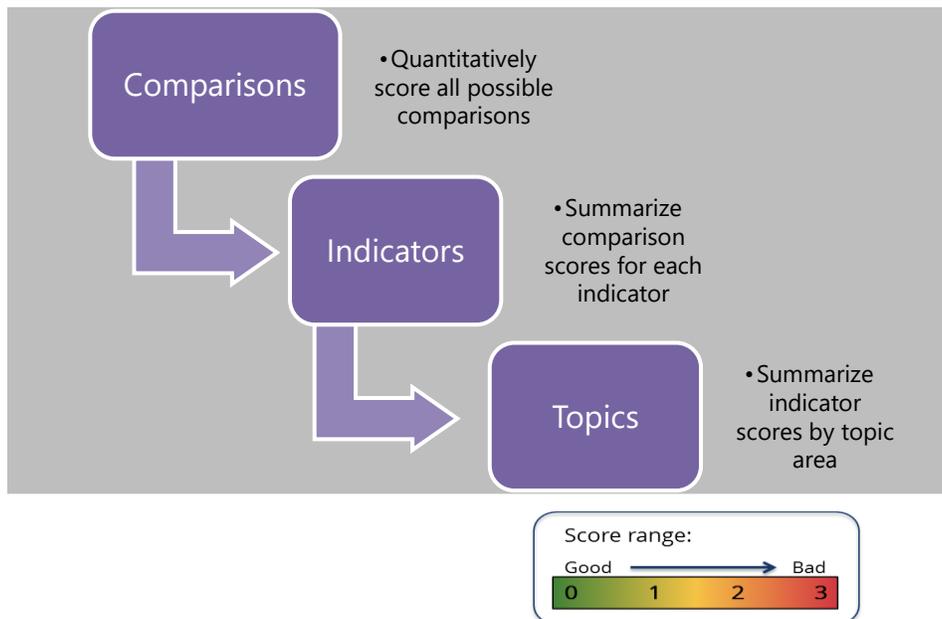
Secondary data used for this assessment were collected and analyzed from the Healthy Northeast Ohio (NEO) community data platform. [Healthy NEO](#) is a publicly available website which houses neutral population health data and community health resources to support community health improvement efforts across a 9-county region. The data on this platform, maintained by researchers and analysts at Conduent HCI, includes over 200 community indicators, spanning at least 24 topics in the areas of health, 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, national targets, and to previous time periods. The following is a list of secondary sources used in Cuyahoga County's Community Health Assessment:

Number	Source
1	American Community Survey
2	Annie E. Casey Foundation
3	CDC - PLACES
4	Centers for Disease Control and Prevention
5	Centers for Medicare & Medicaid Services
6	Claritas Consumer Buying Power
7	Claritas Consumer Profiles
8	County Health Rankings
9	Feeding America
10	Healthy Communities Institute
11	National Cancer Institute
12	National Center for Education Statistics
13	National Environmental Public Health Tracking Network
14	Ohio Department of Education
15	Ohio Department of Health, Infectious Diseases
16	Ohio Department of Health, Vital Statistics
17	Ohio Department of Public Safety, Office of Criminal Justice Services
18	Ohio Public Health Information Warehouse
19	Ohio Secretary of State
20	U.S. Bureau of Labor Statistics
21	U.S. Census - County Business Patterns
22	U.S. Department of Agriculture - Food Environment Atlas
23	U.S. Environmental Protection Agency
24	United For ALICE

## Data Scoring

HCI's Data Scoring Tool systematically summarizes multiple comparisons and ranks indicators based on highest need. For each indicator, the Cuyahoga County value was compared to a distribution of Ohio and U.S. counties, state and national values, Healthy People 2030 targets, and significant trends, as shown below. Each indicator was then given a score based on the available comparisons. These scores range from 0 to 3, where 0 indicates the best outcome and 3 indicates the poorest outcome. Availability of each type of comparison varies by indicator and is dependent upon the data source, comparability with data collected from 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 area.

### Data scoring is done in three stages:



Due to the limited availability of zip code, census tract, or other sub-county health data, the data scoring technique is only available at the county level. The data scoring results are therefore presented in the context of Cuyahoga County. The indicators used in the secondary data analysis for Cuyahoga County can also be accessed on [Healthy Northeast Ohio](#).

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

For ease of interpretation and analysis, indicator data on Healthy Northeast Ohio 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.

## 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.

## 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. 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 the County, and the indicators with the highest race or ethnicity index value were found, with their associated subgroup with the negative disparity highlighted in the [Disparity and Health Equity](#) section of this report.

## 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 (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.

Results for the Cuyahoga County Health Equity Index can be found in the [Disparity and Health Equity](#) section of this report.

## 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 (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.

Results for the Cuyahoga County Food Insecurity Index can be found in the [Disparity and Health Equity](#) section of this report.

## 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 (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.

Results for the Cuyahoga County Mental Health Index can be found in the [Disparity and Health Equity](#) section of this report.

## 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.

## Secondary Data Gauge and Icon Key

### Compare to Distribution (Dial Gauge)

The compare to distribution gauge measures how your community is doing compared to other communities in your state, the U.S. or region. The needle in the **green** means that the selected location is in the best 50% of similar locations, **yellow** represents the 50th to 25th percentile and **red** represents the worst quartile.



### Compare to Target (Circle Gauge)

**The Circle** represents a comparison to a **target value**.

A green circle with a check means that the selected value has met or is better than the target value. A red circle with an "x" means that the selected value has not met the target value.



### Compare to a Value (Diamond Gauge)

**The diamond** represents a comparison to a **single value**. If the arrow points below the line, it means the selected value is lower than the comparison value. If the arrow points above the line, it means the selected value is higher than the comparison value. If there is an equal sign it means there is no difference between the selected value and the comparison value.



### Compare to the Prior Value (Triangle Gauge)

The **triangle** represents a comparison to the **immediate prior value**. If the triangle is pointing up, the value is higher than the previous value, if the triangle points down the value is decreasing and if there is an equal sign there is no change in the value. If the triangle is green it means the change is good, if the triangle is red it means the change is bad.



### Trend over Time (Square Gauge)

**The square** represents a comparison to a **trend over time**. The trend looks at how the indicator is doing over multiple time periods. We analyze up to 10 previous measurement periods (and at least 4) to determine if the value is going up significantly, not significantly, staying the same, decreasing significantly or decreasing not significantly. A solid color gauge means that the change is significant and an outlined gauge means there is a change but it is not significant. A red gauge represents a poor trend and a green gauge represents a positive trend. The blue gauge with an arrow means that going up or down is neither positive or negative and an equal sign means there is no change.

To learn more about how we calculate this rate, please visit the [Mann-Kendall Test for Trend Overview](#).



## Data Scoring Results

The following tables list each indicator by topic area for Cuyahoga County as of May 2022.

SCORE	ADOLESCENT HEALTH	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	SOURCE
1.58	Teen Pregnancy Rate	<i>pregnancies/ 1,000 females aged 15-17</i>	23.9		19.5		2016	17
1.53	Teen Birth Rate: 15-17	<i>live births/ 1,000 females aged 15-17</i>	7.2		6.8		2020	17

SCORE	ALCOHOL & DRUG USE	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	SOURCE
2.64	Death Rate due to Drug Poisoning	<i>deaths/ 100,000 population</i>	42.6		38.1	21	2017-2019	9
2.44	Alcohol-Impaired Driving Deaths	<i>percent of driving deaths with alcohol involvement</i>	41.4	28.3	32.2	27	2015-2019	9
2.00	Adults who Drink Excessively	<i>percent</i>	19.6		18.5	19	2018	9

2.00	Age-Adjusted Drug and Opioid-Involved Overdose Death Rate	<i>Deaths per 100,000 population</i>	39.2		40.4	23.5	2018-2020	5
1.67	Consumer Expenditures: Alcoholic Beverages	<i>average dollar amount per consumer unit</i>	637.1		651.5	701.9	2021	7
1.42	Health Behaviors Ranking		31				2021	9
1.31	Liquor Store Density	<i>stores/ 100,000 population</i>	6.4		5.6	10.5	2019	22
1.25	Adults who Binge Drink	<i>percent</i>	16			16.7	2019	4
0.92	Mothers who Smoked During Pregnancy	<i>percent</i>	6.1	4.3	11.5	5.5	2020	17

SCORE	ALTERNATIVE MEDICINE	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	SOURCE
1.50	Consumer Expenditures: Prescription and Non-Prescription Drugs	<i>average dollar amount per consumer unit</i>	627.2		638.9	609.6	2021	7

SCORE	CANCER	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	SOURCE
2.72	Age-Adjusted Death Rate due to Prostate Cancer	<i>deaths/ 100,000 males</i>	23.8	16.9	19.4	18.9	2015-2019	12
2.58	Breast Cancer Incidence Rate	<i>cases/ 100,000 females</i>	134.8		129.6	126.8	2014-2018	12
2.36	Prostate Cancer Incidence Rate	<i>cases/ 100,000 males</i>	128		107.2	106.2	2014-2018	12
2.31	Cancer: Medicare Population	<i>percent</i>	9		8.4	8.4	2018	6
2.28	Age-Adjusted Death Rate due to Breast Cancer	<i>deaths/ 100,000 females</i>	23.6	15.3	21.6	19.9	2015-2019	12
2.25	All Cancer Incidence Rate	<i>cases/ 100,000 population</i>	479.7		467.5	448.6	2014-2018	12
2.14	Colorectal Cancer Incidence Rate	<i>cases/ 100,000 population</i>	44.2		41.3	38	2014-2018	12
1.78	Age-Adjusted Death Rate due to Cancer	<i>deaths/ 100,000 population</i>	171	122.7	169.4	152.4	2015-2019	12
1.67	Colon Cancer Screening	<i>percent</i>	63.7	74.4		66.4	2018	4

1.44	Age-Adjusted Death Rate due to Lung Cancer	<i>deaths/ 100,000 population</i>	42.9	25.1	45	36.7	2015-2019	12
1.36	Lung and Bronchus Cancer Incidence Rate	<i>cases/ 100,000 population</i>	63.7		67.3	57.3	2014-2018	12
1.28	Age-Adjusted Death Rate due to Colorectal Cancer	<i>deaths/ 100,000 population</i>	14.5	8.9	14.8	13.4	2015-2019	12
1.25	Adults with Cancer	<i>percent</i>	7.5			7.1	2019	4
1.14	Oral Cavity and Pharynx Cancer Incidence Rate	<i>cases/ 100,000 population</i>	11.5		12.2	11.9	2014-2018	12
0.94	Mammogram in Past 2 Years: 50-74	<i>percent</i>	75.2	77.1		74.8	2018	4
0.89	Cervical Cancer Screening: 21-65	<i>Percent</i>	85.3	84.3		84.7	2018	4
0.61	Cervical Cancer Incidence Rate	<i>cases/ 100,000 females</i>	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	<i>percent</i>	20.7		17.4	14.6	2019	10
2.08	Projected Child Food Insecurity Rate	<i>percent</i>	23.4		18.5		2021	10
1.94	Substantiated Child Abuse Rate	<i>cases/ 1,000 children</i>	10	8.7	6.8		2020	3
1.86	Blood Lead Levels in Children (>=10 micrograms per deciliter)	<i>percent</i>	1.7		0.5		2020	19
1.58	Blood Lead Levels in Children (>=5 micrograms per deciliter)	<i>percent</i>	5.8		1.9		2020	19
1.50	Children with Low Access to a Grocery Store	<i>percent</i>	4.3				2015	23
1.33	Children with Health Insurance	<i>percent</i>	97.1		95.2	94.3	2019	1
1.33	Consumer Expenditures: Childcare	<i>average dollar amount per consumer unit</i>	272.1		301.6	368.2	2021	7
SCORE	COMMUNITY	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	SOURCE

2.92	People 65+ Living Alone	<i>percent</i>	35.4		29.4	26.3	2016-2020	1
2.44	Alcohol-Impaired Driving Deaths	<i>percent of driving deaths with alcohol involvement</i>	41.4	28.3	32.2	27	2015-2019	9
2.42	Age-Adjusted Death Rate due to Motor Vehicle Collisions	<i>deaths/ 100,000 population</i>	3.9		2.7	2.6	2016-2020	5
2.36	Households without a Vehicle	<i>percent</i>	12.9		7.8	8.5	2016-2020	1
2.36	Single-Parent Households	<i>percent</i>	38.2		26.9	25.3	2016-2020	1
2.31	Social Associations	<i>membership associations/ 10,000 population</i>	9.2		11	9.3	2018	9
2.19	Homeownership	<i>percent</i>	51.4		60	56.9	2016-2020	1
2.03	Youth not in School or Working	<i>percent</i>	2.4		1.9	1.8	2016-2020	1
2.00	People Living Below Poverty Level	<i>percent</i>	17.1	8	13.6	12.8	2016-2020	1
1.94	Substantiated Child Abuse Rate	<i>cases/ 1,000 children</i>	10	8.7	6.8		2020	3

1.92	Children Living Below Poverty Level	<i>percent</i>	24.8		19.1	17.5	2016-2020	1
1.92	People 65+ Living Alone (Count)	<i>people</i>	79820				2016-2020	1
1.86	Linguistic Isolation	<i>percent</i>	2.6		1.4	4.3	2016-2020	1
1.81	Mean Travel Time to Work	<i>minutes</i>	24.3		23.7	26.9	2016-2020	1
1.75	Median Household Income	<i>dollars</i>	51741		58116	64994	2016-2020	1
1.75	Social and Economic Factors Ranking		72				2021	9
1.75	Young Children Living Below Poverty Level	<i>percent</i>	26.7		21.8	19.1	2016-2020	1
1.69	Voter Turnout: Presidential Election	<i>percent</i>	71		74		2020	20
1.67	Consumer Expenditures: Local Public Transportation	<i>average dollar amount per consumer unit</i>	122.3		121.7	148.8	2021	7
1.64	Violent Crime Rate	<i>crimes/ 100,000 population</i>	881.3				2021	18

1.50	Adults with Internet Access	<i>percent</i>	94.3		94.5	95	2021	8
1.50	Households with a Computer	<i>percent</i>	84.2		85.2	86.3	2021	8
1.36	Solo Drivers with a Long Commute	<i>percent</i>	32.3		31.1	37	2015-2019	9
1.33	Households with a Smartphone	<i>percent</i>	80.3		80.5	81.9	2021	8
1.25	Households with an Internet Subscription	<i>percent</i>	82.1		84.9	85.5	2016-2020	1
1.08	Households with One or More Types of Computing Devices	<i>percent</i>	89.5		90.7	91.9	2016-2020	1
1.08	Persons with an Internet Subscription	<i>percent</i>	86.3		88.3	88.5	2016-2020	1
1.06	Workers Commuting by Public Transportation	<i>percent</i>	4.3	5.3	1.4	4.6	2016-2020	1
1.00	Households with No Car and Low Access to a Grocery Store	<i>percent</i>	1.3				2015	23
0.97	Workers who Walk to Work	<i>percent</i>	2.6		2.2	2.6	2016-2020	1

0.83	Households with Wireless Phone Service	<i>percent</i>	97.2		96.8	97	2020	8
0.75	Workers who Drive Alone to Work	<i>percent</i>	77.3		81.5	74.9	2016-2020	1
0.58	Per Capita Income	<i>dollars</i>	34398		32465	35384	2016-2020	1
0.25	People 25+ with a Bachelor's Degree or Higher	<i>percent</i>	33.5		28.9	32.9	2016-2020	1

SCORE	DIABETES	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	SOURCE
1.50	Adults 20+ with Diabetes	<i>percent</i>	9				2019	5
1.14	Diabetes: Medicare Population	<i>percent</i>	25.3		27.2	27	2018	6
0.86	Age-Adjusted Death Rate due to Diabetes	<i>deaths/ 100,000 population</i>	23.2		26.4	22.6	2018-2020	5
SCORE	DISABILITIES	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	SOURCE

2.36	Persons with Disability Living in Poverty (5-year)	<i>percent</i>	34.8		29.2	25.4	2016-2020	1
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SCORE	ECONOMY	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	SOURCE
2.75	People 65+ Living Below Poverty Level	<i>percent</i>	11.2		8.2	9.3	2016-2020	1
2.50	Unemployed Workers in Civilian Labor Force	<i>percent</i>	6.1		4.8	4.4	January 2022	21
2.36	Persons with Disability Living in Poverty (5-year)	<i>percent</i>	34.8		29.2	25.4	2016-2020	1
2.19	Homeownership	<i>percent</i>	51.4		60	56.9	2016-2020	1
2.17	Child Food Insecurity Rate	<i>percent</i>	20.7		17.4	14.6	2019	10
2.17	Income Inequality		0.5		0.5	0.5	2016-2020	1
2.08	Projected Child Food Insecurity Rate	<i>percent</i>	23.4		18.5		2021	10

2.03	Youth not in School or Working	<i>percent</i>	2.4		1.9	1.8	2016-2020	1
2.00	Adults who Feel Overwhelmed by Financial Burdens	<i>percent</i>	15.1		14.6	14.4	2021	8
2.00	Food Insecurity Rate	<i>percent</i>	13.9		13.2	10.9	2019	10
2.00	Households that are Below the Federal Poverty Level	<i>percent</i>	17.7		13.8		2018	25
2.00	People Living Below Poverty Level	<i>percent</i>	17.1	8	13.6	12.8	2016-2020	1
1.92	Children Living Below Poverty Level	<i>percent</i>	24.8		19.1	17.5	2016-2020	1
1.92	Families Living Below Poverty Level	<i>percent</i>	12.5		9.6	9.1	2016-2020	1
1.92	People 65+ Living Below Poverty Level (Count)	<i>people</i>	24248				2016-2020	1
1.92	Projected Food Insecurity Rate	<i>percent</i>	15.6		14.1		2021	10
1.75	Households with Cash Public Assistance Income	<i>percent</i>	3		2.8	2.4	2016-2020	1

1.75	Median Household Income	<i>dollars</i>	51741		58116	64994	2016-2020	1
1.75	Severe Housing Problems	<i>percent</i>	17.1		13.7	18	2013-2017	9
1.75	Social and Economic Factors Ranking		72				2021	9
1.75	Young Children Living Below Poverty Level	<i>percent</i>	26.7		21.8	19.1	2016-2020	1
1.67	Households that are Above the Asset Limited, Income Constrained, Employed (ALICE) Threshold	<i>percent</i>	58.8		61.6		2018	25
1.64	SNAP Certified Stores	<i>stores/ 1,000 population</i>	0.9				2017	23
1.50	Households with a Savings Account	<i>percent</i>	67.7		68.8	70.2	2021	8
1.42	People Living 200% Above Poverty Level	<i>percent</i>	65.6		69.5	70.2	2016-2020	1
1.42	Renters Spending 30% or More of Household Income on Rent	<i>percent</i>	47.4		44.1	49.1	2016-2020	1

1.33	Consumer Expenditures: Homeowner Expenses	<i>average dollar amount per consumer unit</i>	7600		7828	8900.1	2021	7
1.33	Households that are Asset Limited, Income Constrained, Employed (ALICE)	<i>percent</i>	23.5		24.5		2018	25
1.33	Low-Income and Low Access to a Grocery Store	<i>percent</i>	4.3				2015	23
1.31	Overcrowded Households	<i>percent of households</i>	1.2		1.4		2016-2020	1
1.17	Consumer Expenditures: Home Rental Expenses	<i>average dollar amount per consumer unit</i>	3928.7		3798.7	5460.2	2021	7
1.08	Size of Labor Force	<i>persons</i>	590141				44562	21
1.00	Mortgaged Owners Spending 30% or More of Household Income on Housing	<i>percent</i>	22.7		19.7	26.5	2019	1
0.58	Per Capita Income	<i>dollars</i>	34398		32465	35384	2016-2020	1
0.08	Students Eligible for the Free Lunch Program	<i>percent</i>	12.9		20.2	43.1	2019-2020	13

SCORE	EDUCATION	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	SOURCE
2.14	4th Grade Students Proficient in Math	<i>percent</i>	46.7		59.4		2020-2021	15
2.14	8th Grade Students Proficient in Math	<i>percent</i>	34.3		42.6		2020-2021	15
1.86	4th Grade Students Proficient in English/Language Arts	<i>percent</i>	48.8		56		2020-2021	15
1.67	Consumer Expenditures: Education	<i>average dollar amount per consumer unit</i>	1196.7		1200.4	1492.4	2021	7
1.58	8th Grade Students Proficient in English/Language Arts	<i>percent</i>	45.5		52.7		2020-2021	15
1.44	High School Graduation	<i>percent</i>	89.5	90.7	92		2019-2020	15
1.36	Student-to-Teacher Ratio	<i>students/ teacher</i>	16.3		16.3	16.3	2020-2021	13
1.33	Consumer Expenditures: Childcare	<i>average dollar amount per consumer unit</i>	272.1		301.6	368.2	2021	7

0.25	People 25+ with a Bachelor's Degree or Higher	<i>percent</i>	33.5		28.9	32.9	2016-2020	1
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SCORE	ENVIRONMENTAL HEALTH	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	SOURCE
2.25	Adults with Current Asthma	<i>percent</i>	11			8.9	2019	4
2.14	Fast Food Restaurant Density	<i>restaurants/ 1,000 population</i>	0.9				2016	23
2.08	Houses Built Prior to 1950	<i>percent</i>	38.7		26	17.2	2016-2020	1
2.03	Asthma: Medicare Population	<i>percent</i>	5.2		4.8	5	2018	6
1.86	Blood Lead Levels in Children (>=10 micrograms per deciliter)	<i>percent</i>	1.7		0.5		2020	19
1.75	Annual Ozone Air Quality		F				2017-2019	2
1.75	Physical Environment Ranking		88				2021	9

1.75	Severe Housing Problems	<i>percent</i>	17.1		13.7	18	2013-2017	9
1.67	Farmers Market Density	<i>markets/ 1,000 population</i>	0.02			0.03	2018	23
1.67	People 65+ with Low Access to a Grocery Store	<i>percent</i>	3.4				2015	23
1.64	Number of Extreme Precipitation Days	<i>days</i>	34				2019	14
1.64	SNAP Certified Stores	<i>stores/ 1,000 population</i>	0.9				2017	23
1.58	Blood Lead Levels in Children (>=5 micrograms per deciliter)	<i>percent</i>	5.8		1.9		2020	19
1.53	Food Environment Index		7.3		6.8	7.8	2021	9
1.50	Children with Low Access to a Grocery Store	<i>percent</i>	4.3				2015	23
1.50	WIC Certified Stores	<i>stores/ 1,000 population</i>	0.1				2016	23
1.44	Annual Particle Pollution		B				2017-2019	2

1.36	Number of Extreme Heat Days	<i>days</i>	12				2019	14
1.36	Number of Extreme Heat Events	<i>events</i>	6				2019	14
1.36	Weeks of Moderate Drought or Worse	<i>weeks per year</i>	0				2020	14
1.33	Low-Income and Low Access to a Grocery Store	<i>percent</i>	4.3				2015	23
1.31	Grocery Store Density	<i>stores/ 1,000 population</i>	0.2				2016	23
1.31	Liquor Store Density	<i>stores/ 100,000 population</i>	6.4		5.6	10.5	2019	22
1.31	Overcrowded Households	<i>percent of households</i>	1.2		1.4		2016-2020	1
1.08	PBT Released	<i>pounds</i>	234591.7				2020	24
1.00	Households with No Car and Low Access to a Grocery Store	<i>percent</i>	1.3				2015	23
1.00	Recreation and Fitness Facilities	<i>facilities/ 1,000 population</i>	0.1				2016	23

0.50	Access to Exercise Opportunities	<i>percent</i>	97.5		83.9	84	2020	9
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SCORE	FAMILY PLANNING	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	SOURCE
1.58	Teen Pregnancy Rate	<i>pregnancies/ 1,000 females aged 15-17</i>	23.9		19.5		2016	17
1.53	Teen Birth Rate: 15-17	<i>live births/ 1,000 females aged 15-17</i>	7.2		6.8		2020	17

SCORE	FOOD SAFETY	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	SOURCE
0.83	Salmonella Infection Incidence Rate	<i>cases/ 100,000 population</i>	10.3	11.1	13.7		2019	16

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

1.33	Consumer Expenditures: Health Insurance	<i>average dollar amount per consumer unit</i>	4238.3		4371.7	4321.1	2021	7
1.25	Adults who have had a Routine Checkup	<i>percent</i>	78.2			76.6	2019	4
1.25	Clinical Care Ranking		10				2021	9
0.61	Primary Care Provider Rate	<i>providers/ 100,000 population</i>	112.7		76.7		2018	9
0.33	Dentist Rate	<i>dentists/ 100,000 population</i>	109.6		64.2		2019	9
0.33	Mental Health Provider Rate	<i>providers/ 100,000 population</i>	401.4		261.3		2020	9
0.33	Non-Physician Primary Care Provider Rate	<i>providers/ 100,000 population</i>	180.6		108.9		2020	9
<b>SCORE</b>	<b>HEART DISEASE &amp; STROKE</b>	<b>UNITS</b>	<b>CUYAHOGA COUNTY</b>	<b>HP2030</b>	<b>Ohio</b>	<b>U.S.</b>	<b>MEASUREMENT PERIOD</b>	<b>SOURCE</b>
2.14	Atrial Fibrillation: Medicare Population	<i>percent</i>	9		9	8.4	2018	6
1.92	Adults who Experienced a Stroke	<i>percent</i>	4.2			3.4	2019	4

1.69	Heart Failure: Medicare Population	<i>percent</i>	15.3		14.7	14	2018	6
1.67	Age-Adjusted Death Rate due to Cerebrovascular Disease (Stroke)	<i>deaths/ 100,000 population</i>	37.9	33.4	43.4	37.6	2018-2020	5
1.50	Age-Adjusted Death Rate due to Coronary Heart Disease	<i>deaths/ 100,000 population</i>	105.7	71.1	101.9	90.2	2018-2020	5
1.50	High Blood Pressure Prevalence	<i>percent</i>	35.4	27.7		32.6	2019	4
1.42	Adults who Experienced Coronary Heart Disease	<i>percent</i>	7.4			6.2	2019	4
1.36	Stroke: Medicare Population	<i>percent</i>	3.8		3.8	3.8	2018	6
1.31	Hypertension: Medicare Population	<i>percent</i>	57.2		59.5	57.2	2018	6
1.25	Adults who Have Taken Medications for High Blood Pressure	<i>percent</i>	78.7			76.2	2019	4
1.25	Cholesterol Test History	<i>percent</i>	86.3			87.6	2019	4
1.00	Hyperlipidemia: Medicare Population	<i>percent</i>	45.2		49.4	47.7	2018	6

1.00	Ischemic Heart Disease: Medicare Population	<i>percent</i>	25.8		27.5	26.8	2018	6
0.92	High Cholesterol Prevalence: Adults 18+	<i>percent</i>	32.2			33.6	2019	4
0.58	Age-Adjusted Death Rate due to Heart Attack	<i>deaths/ 100,000 population 35+ years</i>	42.3		55.4		2019	14

SCORE	IMMUNIZATIONS & INFECTIOUS DISEASES	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	SOURCE
2.92	COVID-19 Daily Average Incidence Rate	<i>cases per 100,000 population</i>	16.9		7.6	10.2	44680	11
2.14	Chlamydia Incidence Rate	<i>cases/ 100,000 population</i>	885.9		504.8		2020	16
2.14	Gonorrhea Incidence Rate	<i>cases/ 100,000 population</i>	563.5		262.6		2020	16

2.08	Tuberculosis Incidence Rate	<i>cases/ 100,000 population</i>	1.6	1.4	1.3		2021	16
1.31	Overcrowded Households	<i>percent of households</i>	1.2		1.4		2016-2020	1
1.17	Adults who Agree Vaccine Benefits Outweigh Possible Risks	<i>Percent</i>	48.6		48.6	49.4	2021	8
0.86	Persons Fully Vaccinated Against COVID-19	<i>percent</i>	64.9				44673	5
0.83	Salmonella Infection Incidence Rate	<i>cases/ 100,000 population</i>	10.3	11.1	13.7		2019	16
0.36	Age-Adjusted Death Rate due to Influenza and Pneumonia	<i>deaths/ 100,000 population</i>	11.3		13.9	13.4	2018-2020	5
0.36	COVID-19 Daily Average Case-Fatality Rate	<i>deaths per 100 cases</i>	0		0	3.5	44680	11

SCORE	MATERNAL, FETAL & INFANT HEALTH	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	SOURCE
2.11	Babies with Low Birth Weight	<i>percent</i>	10.8		8.5	8.2	2020	17

2.11	Babies with Very Low Birth Weight	<i>percent</i>	1.7		1.4	1.3	2020	17
1.78	Infant Mortality Rate	<i>deaths/ 1,000 live births</i>	8.6	5	6.9		2019	17
1.67	Preterm Births	<i>percent</i>	11.4	9.4	10.3		2020	17
1.58	Teen Pregnancy Rate	<i>pregnancies/ 1,000 females aged 15-17</i>	23.9		19.5		2016	17
1.53	Teen Birth Rate: 15-17	<i>live births/ 1,000 females aged 15-17</i>	7.2		6.8		2020	17
1.50	WIC Certified Stores	<i>stores/ 1,000 population</i>	0.1				2016	23
1.33	Consumer Expenditures: Childcare	<i>average dollar amount per consumer unit</i>	272.1		301.6	368.2	2021	7
1.00	Mothers who Received Early Prenatal Care	<i>percent</i>	72.4		68.9	76.1	2020	17
0.92	Mothers who Smoked During Pregnancy	<i>percent</i>	6.1	4.3	11.5	5.5	2020	17

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

SCORE	MEN'S HEALTH	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	SOURCE
2.72	Age-Adjusted Death Rate due to Prostate Cancer	<i>deaths/ 100,000 males</i>	23.8	16.9	19.4	18.9	2015-2019	12
2.36	Prostate Cancer Incidence Rate	<i>cases/ 100,000 males</i>	128		107.2	106.2	2014-2018	12

SCORE	MENTAL HEALTH & MENTAL DISORDERS	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	SOURCE
2.17	Alzheimer's Disease or Dementia: Medicare Population	<i>percent</i>	11.4		10.4	10.8	2018	6
1.83	Age-Adjusted Death Rate due to Suicide	<i>deaths/ 100,000 population</i>	14.2	12.8	14.7	13.9	2018-2020	5
1.83	Poor Mental Health: Average Number of Days	<i>days</i>	5		4.8	4.1	2018	9
1.75	Depression: Medicare Population	<i>percent</i>	18.5		20.4	18.4	2018	6
1.75	Poor Mental Health: 14+ Days	<i>percent</i>	16			13.6	2019	4
1.42	Adults Ever Diagnosed with Depression	<i>percent</i>	20.9			18.8	2019	4
1.00	Self-Reported General Health Assessment: Good or Better	<i>percent</i>	85.8		85.6	86.5	2021	8
0.64	Age-Adjusted Death Rate due to Alzheimer's Disease	<i>deaths/ 100,000 population</i>	22.9		35.5	31	2018-2020	5
0.33	Mental Health Provider Rate	<i>providers/ 100,000 population</i>	401.4		261.3		2020	9

SCORE	NUTRITION & HEALTHY EATING	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	SOURCE
1.67	Consumer Expenditures: Fruits and Vegetables	<i>average dollar amount per consumer unit</i>	838.8		864.6	1002.1	2021	7
1.50	Consumer Expenditures: High Sugar Foods	<i>average dollar amount per consumer unit</i>	502.1		519	530.2	2021	7
1.50	WIC Certified Stores	<i>stores/ 1,000 population</i>	0.1				2016	23
1.33	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	<i>Percent</i>	41.1		41.5	41.2	2021	8
1.33	Consumer Expenditures: Fast Food Restaurants	<i>average dollar amount per consumer unit</i>	1415.1		1461	1638.9	2021	7
1.17	Consumer Expenditures: High Sugar Beverages	<i>average dollar amount per consumer unit</i>	310.6		319.7	357	2021	7
0.83	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	<i>percent</i>	79.6		80.9	80.4	2021	8

SCORE	OLDER ADULTS	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	SOURCE
2.92	People 65+ Living Alone	<i>percent</i>	35.4		29.4	26.3	2016-2020	1
2.75	People 65+ Living Below Poverty Level	<i>percent</i>	11.2		8.2	9.3	2016-2020	1
2.31	Cancer: Medicare Population	<i>percent</i>	9		8.4	8.4	2018	6
2.17	Alzheimer's Disease or Dementia: Medicare Population	<i>percent</i>	11.4		10.4	10.8	2018	6
2.14	Age-Adjusted Death Rate due to Falls	<i>deaths/ 100,000 population</i>	11.5		10.8	9.8	2018-2020	5
2.14	Atrial Fibrillation: Medicare Population	<i>percent</i>	9		9	8.4	2018	6
2.08	Osteoporosis: Medicare Population	<i>percent</i>	6.3		6.2	6.6	2018	6
2.03	Asthma: Medicare Population	<i>percent</i>	5.2		4.8	5	2018	6
1.92	Chronic Kidney Disease: Medicare Population	<i>percent</i>	25.2		25.3	24.5	2018	6

1.92	People 65+ Living Alone (Count)	<i>people</i>	79820				2016-2020	1
1.92	People 65+ Living Below Poverty Level (Count)	<i>people</i>	24248				2016-2020	1
1.92	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	<i>percent</i>	35.4		36.1	33.5	2018	6
1.75	Adults 65+ who Received Recommended Preventive Services: Females	<i>percent</i>	28.6			28.4	2018	4
1.75	Depression: Medicare Population	<i>percent</i>	18.5		20.4	18.4	2018	6
1.69	Heart Failure: Medicare Population	<i>percent</i>	15.3		14.7	14	2018	6
1.67	Colon Cancer Screening	<i>percent</i>	63.7	74.4		66.4	2018	4
1.67	People 65+ with Low Access to a Grocery Store	<i>percent</i>	3.4				2015	23
1.58	Adults 65+ with Total Tooth Loss	<i>percent</i>	15.5			13.5	2018	4

1.42	Adults with Arthritis	<i>percent</i>	29.3			25.1	2019	4
1.36	Stroke: Medicare Population	<i>percent</i>	3.8		3.8	3.8	2018	6
1.31	Hypertension: Medicare Population	<i>percent</i>	57.2		59.5	57.2	2018	6
1.14	Diabetes: Medicare Population	<i>percent</i>	25.3		27.2	27	2018	6
1.00	Consumer Expenditures: Eldercare	<i>average dollar amount per consumer unit</i>	20.8		20.5	34.3	2021	7
1.00	Hyperlipidemia: Medicare Population	<i>percent</i>	45.2		49.4	47.7	2018	6
1.00	Ischemic Heart Disease: Medicare Population	<i>percent</i>	25.8		27.5	26.8	2018	6
0.97	COPD: Medicare Population	<i>percent</i>	11.2		13.2	11.5	2018	6
0.92	Adults 65+ who Received Recommended Preventive Services: Males	<i>percent</i>	34.5			32.4	2018	4

0.64	Age-Adjusted Death Rate due to Alzheimer's Disease	<i>deaths/ 100,000 population</i>	22.9		35.5	31	2018-2020	5
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SCORE	ORAL HEALTH	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	SOURCE
1.58	Adults 65+ with Total Tooth Loss	<i>percent</i>	15.5			13.5	2018	4
1.50	Adults who Visited a Dentist	<i>percent</i>	51.3		51.6	52.9	2021	8
1.14	Oral Cavity and Pharynx Cancer Incidence Rate	<i>cases/ 100,000 population</i>	11.5		12.2	11.9	2014-2018	12
0.33	Dentist Rate	<i>dentists/ 100,000 population</i>	109.6		64.2		2019	9

SCORE	OTHER CONDITIONS	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	SOURCE
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2.08	Osteoporosis: Medicare Population	<i>percent</i>	6.3		6.2	6.6	2018	6
1.92	Adults with Kidney Disease	<i>Percent of adults</i>	3.6			3.1	2019	4
1.92	Chronic Kidney Disease: Medicare Population	<i>percent</i>	25.2		25.3	24.5	2018	6
1.92	Rheumatoid Arthritis or Osteoarthritis: Medicare Population	<i>percent</i>	35.4		36.1	33.5	2018	6
1.69	Age-Adjusted Death Rate due to Kidney Disease	<i>deaths/ 100,000 population</i>	15.5		14.2	12.8	2018-2020	5
1.42	Adults with Arthritis	<i>percent</i>	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	<i>percent</i>	34.2	36			2019	5
2.14	Fast Food Restaurant Density	<i>restaurants/ 1,000 population</i>	0.9				2016	23

1.67	Farmers Market Density	<i>markets/ 1,000 population</i>	0.02			0.03	2018	23
1.67	People 65+ with Low Access to a Grocery Store	<i>percent</i>	3.4				2015	23
1.64	Adults 20+ who are Sedentary	<i>percent</i>	25.1				2019	5
1.64	SNAP Certified Stores	<i>stores/ 1,000 population</i>	0.9				2017	23
1.53	Food Environment Index		7.3		6.8	7.8	2021	9
1.50	Children with Low Access to a Grocery Store	<i>percent</i>	4.3				2015	23
1.42	Health Behaviors Ranking		31				2021	9
1.33	Low-Income and Low Access to a Grocery Store	<i>percent</i>	4.3				2015	23
1.31	Grocery Store Density	<i>stores/ 1,000 population</i>	0.2				2016	23
1.00	Households with No Car and Low Access to a Grocery Store	<i>percent</i>	1.3				2015	23

1.00	Recreation and Fitness Facilities	<i>facilities/ 1,000 population</i>	0.1				2016	23
0.97	Workers who Walk to Work	<i>percent</i>	2.6		2.2	2.6	2016-2020	1
0.83	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	<i>percent</i>	79.6		80.9	80.4	2021	8
0.50	Access to Exercise Opportunities	<i>percent</i>	97.5		83.9	84	2020	9

SCORE	PREVENTION & SAFETY	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	SOURCE
2.64	Death Rate due to Drug Poisoning	<i>deaths/ 100,000 population</i>	42.6		38.1	21	2017-2019	9
2.42	Age-Adjusted Death Rate due to Motor Vehicle Collisions	<i>deaths/ 100,000 population</i>	3.9		2.7	2.6	2016-2020	5
2.14	Age-Adjusted Death Rate due to Falls	<i>deaths/ 100,000 population</i>	11.5		10.8	9.8	2018-2020	5
1.86	Age-Adjusted Death Rate due to Unintentional Poisonings	<i>deaths/ 100,000 population</i>	39.3		40.5	23.5	2018-2020	5

1.75	Age-Adjusted Death Rate due to Unintentional Injuries	<i>deaths/ 100,000 population</i>	67.5	43.2	69.9	51.6	2018-2020	5
1.75	Severe Housing Problems	<i>percent</i>	17.1		13.7	18	2013-2017	9

SCORE	RESPIRATORY DISEASES	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	SOURCE
2.92	COVID-19 Daily Average Incidence Rate	<i>cases per 100,000 population</i>	16.9		7.6	10.2	44680	11
2.25	Adults with Current Asthma	<i>percent</i>	11			8.9	2019	4
2.08	Tuberculosis Incidence Rate	<i>cases/ 100,000 population</i>	1.6	1.4	1.3		2021	16
2.03	Asthma: Medicare Population	<i>percent</i>	5.2		4.8	5	2018	6
2.00	Consumer Expenditures: Tobacco and Legal Marijuana	<i>average dollar amount per consumer unit</i>	485.5		487.9	422.4	2021	7
1.58	Adults with COPD	<i>Percent of adults</i>	8.6			6.6	2019	4

1.44	Age-Adjusted Death Rate due to Lung Cancer	<i>deaths/ 100,000 population</i>	42.9	25.1	45	36.7	2015-2019	12
1.42	Adults who Smoke	<i>percent</i>	20.9	5	21.4	17	2018	9
1.36	Lung and Bronchus Cancer Incidence Rate	<i>cases/ 100,000 population</i>	63.7		67.3	57.3	2014-2018	12
0.97	COPD: Medicare Population	<i>percent</i>	11.2		13.2	11.5	2018	6
0.83	Adults Who Used Electronic Cigarettes: Past 30 Days	<i>percent</i>	4		4.3	4.1	2021	8
0.53	Age-Adjusted Death Rate due to Chronic Lower Respiratory Diseases	<i>deaths/ 100,000 population</i>	37.4		46.5	38.1	2018-2020	5
0.50	Adults Who Used Smokeless Tobacco: Past 30 Days	<i>percent</i>	1.2		2.2	2	2021	8
0.36	Age-Adjusted Death Rate due to Influenza and Pneumonia	<i>deaths/ 100,000 population</i>	11.3		13.9	13.4	2018-2020	5
0.36	COVID-19 Daily Average Case-Fatality Rate	<i>deaths per 100 cases</i>	0		0	3.5	44680	11

SCORE	SEXUALLY TRANSMITTED INFECTIONS	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	SOURCE
2.14	Chlamydia Incidence Rate	<i>cases/ 100,000 population</i>	885.9		504.8		2020	16
2.14	Gonorrhea Incidence Rate	<i>cases/ 100,000 population</i>	563.5		262.6		2020	16

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

0.50	Adults Who Used Smokeless Tobacco: Past 30 Days	<i>percent</i>	1.2		2.2	2	2021	8
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SCORE	WEIGHT STATUS	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	SOURCE
2.22	Adults 20+ Who Are Obese	<i>percent</i>	34.2	36			2019	5

SCORE	WELLNESS & LIFESTYLE	UNITS	CUYAHOGA COUNTY	HP2030	Ohio	U.S.	MEASUREMENT PERIOD	SOURCE
2.58	Insufficient Sleep	<i>percent</i>	44.9	31.4	40.6	35	2018	9
1.75	Morbidity Ranking		76				2021	9
1.67	Poor Physical Health: Average Number of Days	<i>days</i>	4.2		4.1	3.7	2018	9
1.58	Poor Physical Health: 14+ Days	<i>percent</i>	14.3			12.5	2019	4

1.58	Self-Reported General Health Assessment: Poor or Fair	<i>percent</i>	21.1			18.6	2019	4
1.50	High Blood Pressure Prevalence	<i>percent</i>	35.4	27.7		32.6	2019	4
1.50	Life Expectancy	<i>years</i>	77		77	79.2	2017-2019	9
1.33	Adults Who Frequently Used Quick Service Restaurants: Past 30 Days	<i>Percent</i>	41.1		41.5	41.2	2021	8
1.33	Consumer Expenditures: Fast Food Restaurants	<i>average dollar amount per consumer unit</i>	1415.1		1461	1638.9	2021	7
1.17	Adults who Agree Vaccine Benefits Outweigh Possible Risks	<i>Percent</i>	48.6		48.6	49.4	2021	8
1.00	Self-Reported General Health Assessment: Good or Better	<i>percent</i>	85.8		85.6	86.5	2021	8
0.83	Adult Sugar-Sweetened Beverage Consumption: Past 7 Days	<i>percent</i>	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	<i>cases/ 100,000 females</i>	134.8		129.6	126.8	2014-2018	12
2.28	Age-Adjusted Death Rate due to Breast Cancer	<i>deaths/ 100,000 females</i>	23.6	15.3	21.6	19.9	2015-2019	12
0.94	Mammogram in Past 2 Years: 50-74	<i>percent</i>	75.2	77.1		74.8	2018	4
0.89	Cervical Cancer Screening: 21-65	<i>Percent</i>	85.3	84.3		84.7	2018	4

# Appendix C: Community Input Assessment Tools

## I. Key Informant Facilitation Guide

**WELCOME:** The Health Improvement Partnership-Cuyahoga (HIP-Cuyahoga) is in the process of conducting their 2022 comprehensive Community Health Needs Assessment (CHNA) to understand and plan for current and future health needs of Cuyahoga County.

You have been invited to take part in this interview because of your experience working 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 organization serves and how to improve health in Cuyahoga County. 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.

**[TURN ON TRANSCRIPTION IN TEAMS AT THIS TIME]**

**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.

The Cuyahoga County Board of Health, City of Cleveland, University Hospital, MetroHealth, Southwest General and St. Vincent hospital is further collaborating with Cleveland Clinic on their CHNA processes through information sharing. Though still confidential (without associated names or other identifiers), results of this cumulative qualitative data collection process will be reported in both assessments.

**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?
  - What population do you serve?

### 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?
  - Are there 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?
  - What activities exist or what else can be done to address issues of structural racism?
  - What else can be done to enhance issues of trust?

### **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.

## II. Focus Group Facilitation Guides

### A. Adult Facilitation Guide

#### INTRODUCTION

{Introduce Yourself and Others on the Team.}

{"Let's get started..."}

Opening Script: Thank you for taking the time to speak with us to support the Health Improvement Partnership-Cuyahoga (HIP-Cuyahoga) Community Health Needs Assessment for Cuyahoga County. We anticipate that this discussion will last no more than 60 minutes. You have been invited to take part in this focus group because of your experience living and/or working in Cuyahoga County. The focus of this assessment is how to improve health in the community and understand what challenges residents are facing. We are going to ask a series of questions related to health issues in the community. We hope to get through as many questions as possible and hear each of your perspectives as much as time allows.

For this discussion group, I will invite you to share as much or little as you feel comfortable sharing with the others in the group. The results of this assessment will be made available to the public. We will be taking notes on your responses, but your names will not be associated with any direct quotes. Your identity will be kept confidential, so please share your honest opinions.

We do have a few ground rules for this virtual discussion that I would like to review with you. It is important that everyone has a chance to be heard, so we ask that only one person talks at a time (most important ground rule for today). You may use the "raise hand" functions when you have something to say *[give instructions and test]*. We may also call on you to sure ensure everyone has a chance to speak but if you have nothing to share, please just say "pass".

You may want to mute yourself when you are not speaking to cut down on background noise *[give instructions and test mute/unmute]*. Finally, please respect the opinions of others, as the point of the discussion is to collect various points of view. And remember, there are no right or wrong answers, so please share freely and openly. Does anyone have any questions before we get started?

Okay, let's get started by going around and introducing ourselves. Please tell everyone your first name, what community you live in, and if you are interested in sharing, your involvement in the community (could be your job or volunteer work for example).

*{Introductions}*

Thank you for introducing yourselves. Now we will get started with our discussion.

#### **Section #1: 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 #2: Barriers to Health**

- 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?

- Are there particular parts of the community or geographic areas that are underserved or under-resourced?
- What services are most difficult to access?
- What health disparities appear most prevalent in your community?
- What could be done to promote health equity?
- What activities exist or what else can be done to address issues of structural racism?
  - What else can be done to enhance issues of trust?

### **Section #3: COVID-19**

- We'd like to know how the pandemic has impacted you, your life, and your community. How has COVID-19 impacted you and your community?
  - Did you or anyone you know have challenges seeking care?
  - How have you and your family coped?

### **Section #4: 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?

### **Section #5: Community Resources**

What resources does your community have that can be used to improve community health?

- What additional programs and resources do you think are needed to best meet the needs of residents in Cuyahoga County?
- Do you see residents taking advantage of them? Why or why not?

### **Section #6: Conclusion**

{I just have one more question as we close out our discussion today.}

- Is there anything else that you think would be important for us to know as we conduct this community health needs assessment?
  - Can you think of any other ways we could improve the health of residents in the community that we have not already talked about today?

{Check if note taker needs any clarification}

**CLOSURE SCRIPT:** Thank you very much for your time and willingness to share your experiences with us today. We will include your comments in our data to describe how health can be improved for residents in your community. 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.

## B. Youth Facilitation Guide

### INTRODUCTION

{Introduce Yourself and Others on the Team.}

{"Let's get started..."}

**Opening Script:** Thank you for taking the time to speak with us to support the Health Improvement Partnership-Cuyahoga (HIP-Cuyahoga) Community Health Needs Assessment for Cuyahoga County. We anticipate that this discussion will last no more than 60 minutes. You have been invited to take part in this focus group because of your experience living and/or working in Cuyahoga County. The focus of this assessment is how to improve health in the community and understand what challenges residents are facing. We are going to ask a series of questions related to health issues in the community. We hope to get through as many questions as possible and hear each of your perspectives as much as time allows.

For this discussion group, I will invite you to share as much or little as you feel comfortable sharing with the others in the group. The results of this assessment will be made available to the public. We will be taking notes on your responses, but your names will not be associated with any direct quotes. Your identity will be kept confidential, so please share your honest opinions.

We do have a few ground rules for this virtual discussion that I would like to review with you. It is important that everyone has a chance to be heard, so we ask that only one person talks at a time (most important ground rule for today). You may use the "raise hand" functions when you have something to say [give instructions and test]. We may also call on you to sure ensure everyone has a chance to speak but if you have nothing to share, please just say "pass".

You may want to mute yourself when you are not speaking to cut down on background noise [give instructions and test mute/unmute]. Finally, please respect the opinions of others, as the point of the discussion is to collect various points of view. And remember, there are no right or wrong answers, so please share freely and openly. Does anyone have any questions before we get started?

Okay, let's get started by going around and introducing ourselves. Please tell everyone your first name, what community you live in, and if you are interested in sharing, your involvement in the community (could be your job or volunteer work for example).

{Introductions}

Thank you for introducing yourselves. Now we will get started with our discussion.

#### **Section #1: 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 #2: Barriers to Health**

- 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?
  - Are there particular parts of the community or geographic areas that are underserved or under-resourced?
  - What services are most difficult to access?

- What are some preventable differences in people’s health or their access to health care that are most common in your community?
- What could be done to make sure that everyone in your community has the opportunity to live up to his or her full health potential?
- What activities exist or what else could be done to address the ways society discriminates against individuals or particular communities? (Examples could be discrimination in employment or access to healthcare).
  - What else can be done to enhance issues of trust?

**Section #3: COVID-19**

- We’d like to know how the pandemic has impacted you, your life, and your community. How has COVID-19 impacted you and your community?
  - Did you or anyone you know have challenges seeking care?
  - How have you and your family coped?

**Section #4: 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?

**Section #5: Community Resources**

What resources does your community have that can be used to improve community health?

- What additional programs and resources do you think are needed to best meet the needs of residents in Cuyahoga County?
- Do you see residents taking advantage of them? Why or why not?

**Section #6: Conclusion**

{I just have one more question as we close out our discussion today.}

- Is there anything else that you think would be important for us to know as we conduct this community health needs assessment?
  - Can you think of any other ways we could improve the health of residents in the community that we have not already talked about today?

{Check if note taker needs any clarification}

**CLOSURE SCRIPT:** Thank you very much for your time and willingness to share your experiences with us today. We will include your comments in our data to describe how health can be improved for residents in your community. 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.



### III. Prioritization Support Documents

#### A. Data Synthesis Presentation Thought Catcher

##### 2022 Cuyahoga County CHNA Prioritization Meeting

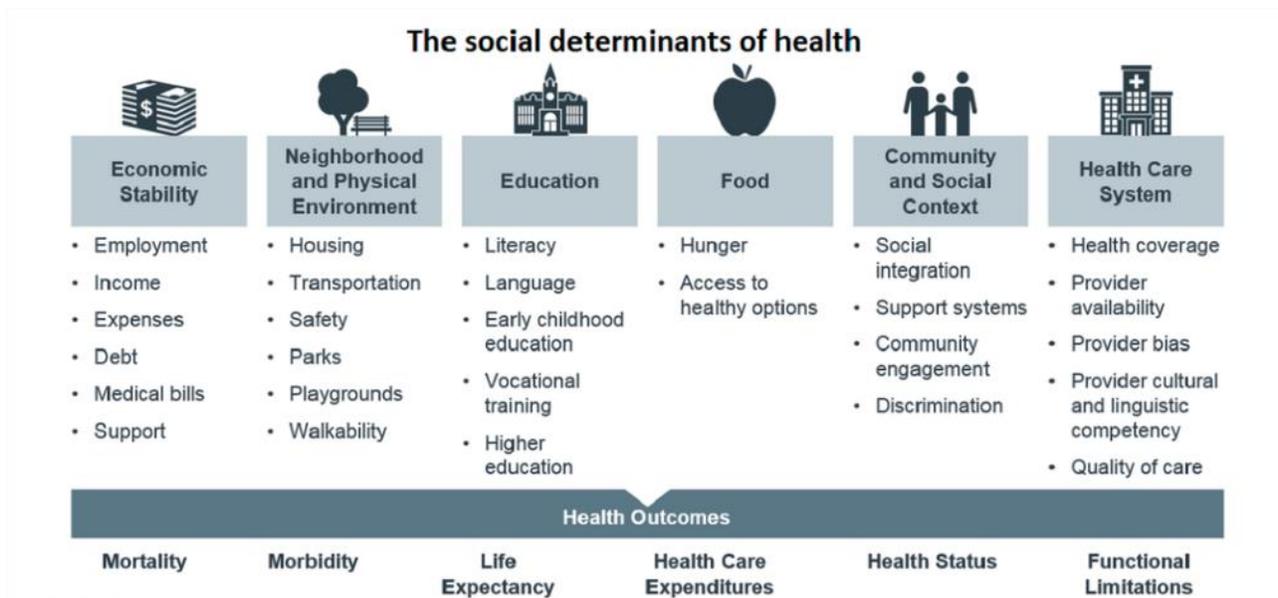
##### Thought Catcher

Please use this as a tool to capture your initial reactions to the CHNA results as the data are shared for each of the categories below. Capture your general thoughts and/or responses to the question prompts. This will help you contribute to the small group discussion that will follow. Thank you for adding your voice to our community conversation.

##### Key terms and ideas to keep in mind for common understanding:

Social Determinants of Health (SDOH): Refer to “nonmedical factors such as employment, income, housing, transportation, child care, education, discrimination, and the quality of the places where people live, work, learn, and play, which influence health.” (American Public Health Association)

*“The barriers to health equity are rooted in a concept called the Social Determinants of Health (SDoH). Simply stated, SDOH are factors created by an individual’s social conditions that can be used to indicate whether the person has the opportunity to pursue their best health possible.” – The Conscious Collaboration Pathway™, S. Brown*



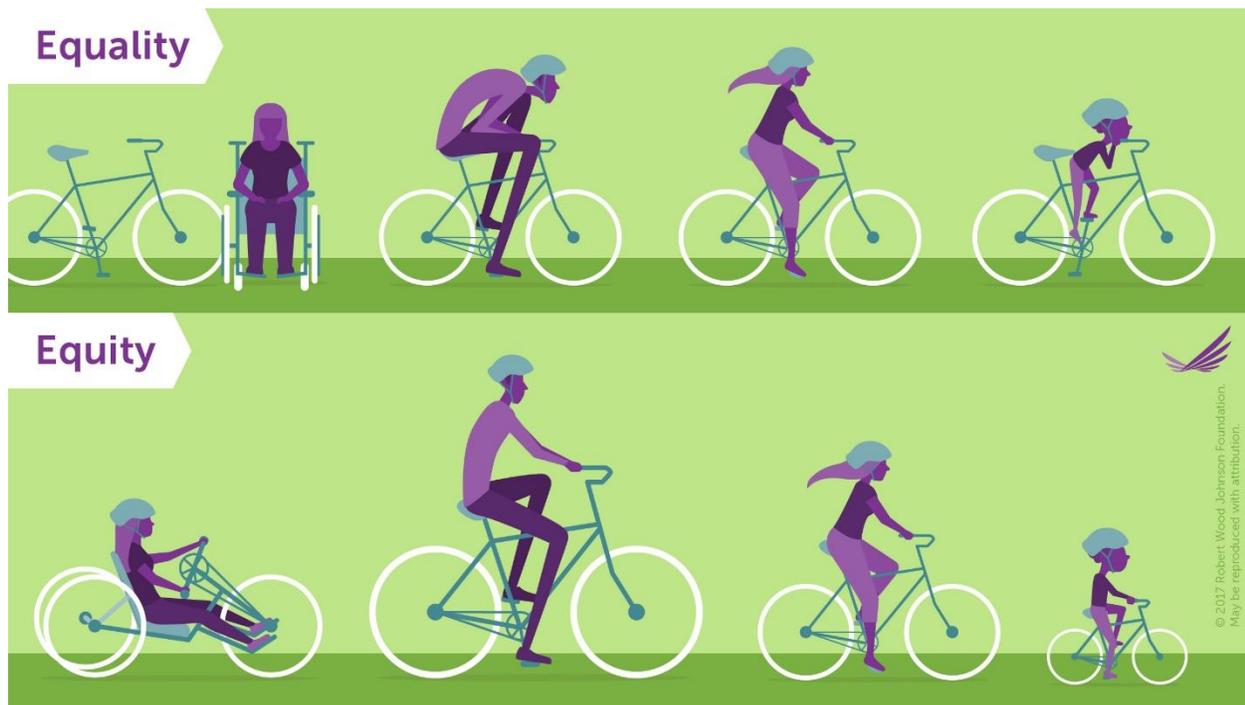
Source: Adapted from Kaiser Family Foundation by Center for Integrated Healthcare

**Health Equity:** “Health equity means that everyone has a fair and just opportunity to be healthier. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care.” (Robert Wood Johnson Foundation)

**Health Inequity:** refers to the uneven distribution of social and economic resources that impact an individual’s health. Inequities in health often result in disparities in health outcomes between populations within the United States. (American Public Health Association)

**Health Disparity:** refers to “a difference in health that is closely linked with social, economic, and/or environmental disadvantage.” In order to advance health equity public health must work with other sectors to address the social determinants of health. (American Public Health Association)

### Visualizing Health Equity: One Size Does Not Fit All



Source: Robert Wood Johnson Foundation

**Thought Catcher:**

Category: Accessible and Affordable Healthcare

<i>What stands out for you about each area of need as you hear the data presentation?</i>	<i>What are your initial thoughts about the connection between the data and the SDoH?</i>

Category: Access to Healthy Food

<i>What stands out for you about each area of need as you hear the data presentation?</i>	<i>What are your initial thoughts about the connection between the data and the SDoH?</i>

Category: Behavioral Health (Including Mental Health and Drug & Alcohol Use/Misuse)

<i>What stands out for you about each area of need as you hear the data presentation?</i>	<i>What are your initial thoughts about the connection between the data and the SDoH?</i>

Category: Community Safety

<i>What stands out for you about each area of need as you hear the data presentation?</i>	<i>What are your initial thoughts about the connection between the data and the SDoH?</i>

Category: Economy

<i>What stands out for you about each area of need as you hear the data presentation?</i>	<i>What are your initial thoughts about the connection between the data and the SDoH?</i>

Category: Education

<i>What stands out for you about each area of need as you hear the data presentation?</i>	<i>What are your initial thoughts about the connection between the data and the SDoH?</i>

Category: Environmental Health

<i>What stands out for you about each area of need as you hear the data presentation?</i>	<i>What are your initial thoughts about the connection between the data and the SDoH?</i>

Category: Maternal, Fetal, & Infant Health

<i>What stands out for you about each area of need as you hear the data presentation?</i>	<i>What are your initial thoughts about the connection between the data and the SDoH?</i>

Category: Older Adults

<i>What stands out for you about each area of need as you hear the data presentation?</i>	<i>What are your initial thoughts about the connection between the data and the SDoH?</i>

Category: Structural and Institutional Racism

<i>What stands out for you about each area of need as you hear the data presentation?</i>	<i>What are your initial thoughts about the connection between the data and the SDoH?</i>

## B. Prioritization “Cheat Sheet”

### Prioritization Cheat Sheet: Cuyahoga County

#### 2022 Community Health Needs Assessment

**Purpose:** You have been invited to participate in a virtual prioritization activity. The purpose of this activity is to guide the decision on which "prioritized" health areas the Hospitals, Health Departments, and community organizations in Cuyahoga County will focus on for the next three to five years. We anticipate it will take ~10 minutes to complete this exercise.

**Recommendations:** For optimal user experience, use a laptop or desktop computer. If you must use a tablet or cell phone, hold in landscape mode and scroll horizontally to ensure all questions are answered.

**Handouts:** We recommend you have this Prioritization Cheat Sheet available for easy reference.

**Scoring:** Please assign a score of **1 to 5** for each health topic and criteria using the guidance outlined below where:

#### MAGNITUDE

How **BIG** an issue is each health issue?

##### Considerations:

- How many people in the community are or will be impacted?
- How does each need impact health and quality of life?
- Has the need changed over time?

#### ABILITY TO IMPACT

Do you feel the groups taking on this work will be able to have a **positive impact** on each health issue?

##### Considerations:

- Do the hospitals, health departments, or community organizations have the knowledge, experience or resources to address the health need?
- Can the need be addressed in collaboration with community partners? Are organizations already addressing the health issue?
- Can we create clear goals to address the health need? Are those goals achievable in the next few years?

#### INEQUITIES / SOCIAL DETERMINANTS OF HEALTH

Do inequities exist or is there influence of any social or economic factors?

##### Considerations:

- Do inequities exist for each health issue?
- Are there Social Determinants of Health that influence this health issue to be better or worse?
- Does this issue impact some populations or communities more than others?

\*The health needs in the table below are listed in alphabetical order (not by order of importance)

<b>Health Need*</b>	<b>Magnitude of the Issue</b> Assign a score of 1 to 5: 1 - Not a serious issue/small population effected 2 3 - Somewhat serious issue/some population effected 4 5 - Serious issue/large population effected	<b>Ability to Impact</b> Assign a score of 1 to 5: 1 -Not much that can be done 2 3 - There is some change/improvement that can be made 4 5 - There is a great opportunity to make a positive change/improvement	<b>Inequities/Social Determinants of Health</b> Assign a score of 1 to 5: 1 - No inequities/No SDOH influence 2 3 - Some inequities/Some SDOH influence 4 5 - Large inequities/Large SDOH influence
<b>Accessible and Affordable Healthcare</b> (Including: Healthy Literacy/Knowledge/ Outreach)			
<b>Access to Healthy Food</b> (Including: Food Insecurity)			
<b>Behavioral Health</b> (Including: Mental Health and Drug & Alcohol Use/Misuse) and Social Cohesion and Connectedness (Social Isolation)			
<b>Community Safety</b> (Prevention & Safety)			

<b>Economy</b> (Good/accessible jobs and fair/equitable wages)			
<b>Education</b> (Literacy Gaps)			
<b>Environmental Health</b> (Including: Safe & Affordable Housing and Pediatric Lead Exposure)			
<b>Maternal, Fetal, &amp; Infant Health</b> (Specifically: Infant and Maternal Mortality)			
<b>Older Adults</b>			
<b>Structural and Institutional Racism</b>			