



2025 IN REVIEW

Sana Sana Colita de Rana is an original artwork by Cleveland artist DayzWhun commissioned for Via Sana. You can learn more about DayzWhun at 4030studios.com. Photo by Bob Perkowski.

2025 Year in Review

In 2025, the Institute for H.O.P.E.™ continued to meet its promise to address the social drivers of health to improve the health and quality of life for our patients and community. Despite challenges and uncertainties in the healthcare industry, our commitment to this work, our patients and the community has not wavered.

In addition to the other highlights you will see in this report, in 2025:

- We began working closely with our Care Management colleagues to reaffirm our commitment to address our patients' social needs as a component of overall care and to develop seamless ways to respond when patients want assistance.
- We developed and implemented a process for screening older adult patients for age-related social vulnerabilities, contributing to MetroHealth's work to become an Age Friendly Health System, a national standard to ensure the delivery of high quality care to patients age 65 and older.
- Our Center for Arts in Health sustained its commitment to improving how our built environment supports well being. In partnership with LAND studio, the team procured and commissioned 126 artworks in 13 ambulatory health centers, School Health Program clinics and neighborhoods. A highlight included the installation of the mural by DayzWhun at Via Sana, featured on the cover of this report.
- Working in partnership with Cleveland Peacemakers and with support from a Neighborhood Safety grant through the City of Cleveland, we are embedding a Hospital Responder in our Emergency Department, working to deescalate the potential spread of retaliatory violence back in the community.
- Three of our leaders completed Quality Improvement training using the Institute for Healthcare Improvement's model, adding expertise that will help us maintain a continuous focus on excellence.

Late this year, the Institute for H.O.P.E. joined forces with MetroHealth's Care Management and Quality divisions within the Population Health Innovation Institute. This new, expanded Institute for H.O.P.E. will help to ensure our focus on social drivers of health is deeply integrated into the care MetroHealth delivers. We look forward to updating you next year on those efforts.

We hope you take time to read this report and learn more about the ways we improved the lives and health of our patients and the community in 2025. Thank you for your partnership and support.

With gratitude,

Matthew Kaufmann, Executive Director, Care Management

Karen Cook, Director, Healthy Families & Thriving Communities, Institute for H.O.P.E.

Screening for Social Drivers of Health

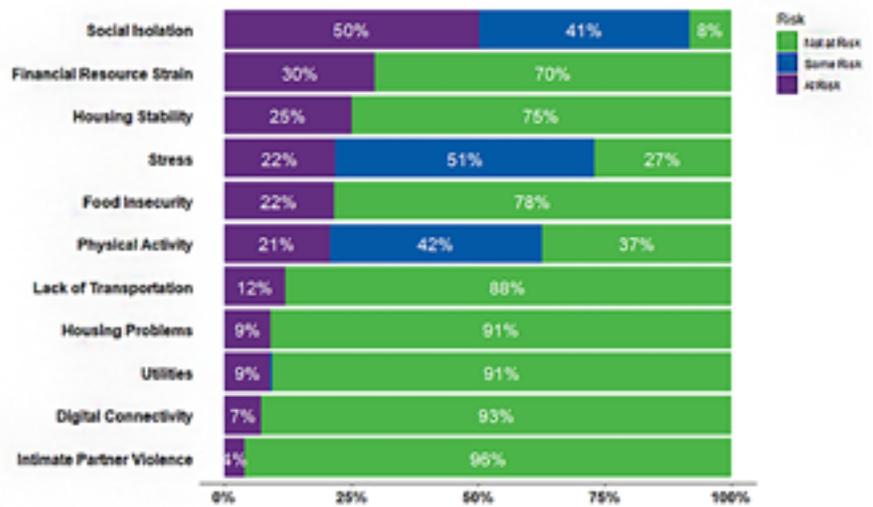
Health is shaped by factors beyond clinical care – like access to food, safe and affordable housing, and financial stability. MetroHealth is committed to improving health and well-being by identifying and addressing these social needs through proactive screening and resource connections.

In 2025, we made a commitment to focus these efforts on patients who are receiving primary care at MetroHealth. Social Drivers of Health (SDOH) screening is available on MyChart 30 days in advance of primary care appointments, via text for patients not using MyChart, and through various engagements with Care Management staff.

We also expanded screening for patients in crisis and during acute illnesses when the impact of unmet social needs is even more pronounced. In early 2025, we launched SDOH screening in our Behavioral Health Hospital, where 98% of admitted patients were screened and connected with follow-up support as needed. We also continued to screen in all other inpatient settings, where 79% of patients were screened.

Early evaluation of this work demonstrates the impact: Preliminary analysis indicates that patients who requested and received support were 15% less likely to be readmitted to the hospital and 15% less likely to return to the emergency department within 30 days of discharge, compared to those who screened at risk but did not request help. These promising results are undergoing further evaluation.

Overall, in 2025 we screened a total of 74,961 unique patients for their health-related social needs. The chart to the right shows the results.



Beyond screening for social needs, MetroHealth is committed to responding when patients ask for help. In 2025, we supported patients through referrals to internal programs like Food as Medicine and Financial Coaching, engagement with Community Health Workers and connections to on-site partners at our Opportunity Center at Buckeye. We also made direct electronic referrals to community organizations via Unite Ohio – a coordinated-care network linking people to vital resources like food, utility help and transportation.

553 registered MetroHealth users

264 community partners serving Cuyahoga County

4,996 referrals by MetroHealth users

2,984 unique MetroHealth patients served

From 2025 data

To learn more, visit ohio.uniteus.com.

Food as Medicine



Photo of FAM cooking class in the *Vía Sana* kitchen

Impact



FAM provided **272** patients with **2,079** healthy food packages, supplying enough nutritious food for **47,583** meals.

Martin*, a 2025 FAM graduate, achieved remarkable health improvements during the program, reducing his blood pressure from 168/98 to 125/70 and lowering his A1c by 2 points.

**Name changed for confidentiality*

The **Food as Medicine Clinic (FAM)** is a medically tailored grocery program that supports patients experiencing food insecurity and managing chronic health conditions influenced by diet, such as diabetes and hypertension.

Eligible patients receive a three-day supply of nutritious food for their household every two weeks, for up to one

year. Participants also benefit from nutrition education and can attend monthly cooking classes.

In 2025, FAM expanded to serve food insecure pregnant patients through **Nourishing Tomorrow**, a National Institutes of Health-funded collaborative study among Case Western Reserve University, Greater Cleveland Food Bank, MetroHealth, and University Hospitals.

Community Advocacy Program



The
Legal Aid Society
of Cleveland
Since 1905

Created at MetroHealth 23 years ago, the **Community Advocacy Program (CAP)** is a medical-legal partnership which aims to overcome legal barriers to good health. Physicians, nurses, social workers and other care team members partner with lawyers from **The Legal Aid Society of Cleveland** – based on-site at MetroHealth, to connect patients with legal help.

They can address civil legal issues that interfere with health, including housing conditions, barriers to education services, public benefits denial, housing evictions, family matters and immigration. In 2025 this service expanded to support individuals impacted by substance use disorder.

Impact



CAP served **400** patients with civil legal issues, impacting **1,195** household members.

A new MetroHealth patient – a mother caring for a newborn and another child with a serious medical condition – recently moved from out of state and was struggling to transfer her food assistance and health insurance benefits to Ohio.

A MetroHealth social worker connected her with a Legal Aid attorney, who quickly helped reinstate her benefits. With that support, the family regained reliable access to food and no longer had to worry about meeting their medical needs.

Opportunity Centers



The **Opportunity Centers at Via Sana** and **Buckeye** are neighborhood-based hubs that connect patients and residents to programs and services to meet their health-related social needs.

Each Center offers different services, including educational workshops, cooking classes, financial literacy training and community event and meeting space. The **Opportunity Center at Buckeye** also houses community-based organizations that provide access to utility assistance, job readiness training, legal support and more. Together, these Centers support individuals in addressing economic and health barriers and achieving long-term well-being.

Impact



Via Sana: Served **1,109** individuals, and hosted **177** community workshops.



Buckeye: Served **5,576** individuals, delivered **1,214** financial coaching sessions, and helped **323** individuals achieve a financial goal (manage budget, increase savings, reduce debt and improve credit).

Digital Navigator Program



The **Digital Navigator Program** helps patients overcome barriers to digital access and literacy, ensuring they can fully engage in their healthcare.

Through a partnership with **DigitalC** and funding from the **City of Cleveland**, the program focuses on residents with high social vulnerability who lack internet access, devices or digital skills. Services include MyChart activation and navigation, and digital literacy training.

Impact



1,387 patients reached with various digital navigation services



671 patients engaged through MyChart Quality Improvement text campaign, resulting in **104** new MyChart activations



Hosted **4** workshops to help patients with internet access, device set-up, and digital skills.

Healthy Housing: Aging in Place



Impact



- **12** homes in Cleveland's Buckeye neighborhood were identified to receive safety modifications



- Thanks to our partnership with Community Housing Solutions, many residents received essential repairs beyond safety features, in total valued at more than **\$150,000**, including bathroom remodels, electrical work and new flooring, strengthening long-term housing stability.

The **Aging in Place Program** helps older adults and people with disabilities stay safe and comfortable at home. In partnership with **Community Housing Solutions**, the program offers free occupational therapy assessments and home safety modifications to reduce fall risks and make daily life easier.

Modifications may include grab bars, handrails, raised toilet seats, better lighting and the removal of trip hazards. These changes help residents stay safe and independent while remaining connected to the neighborhood they've long called home.

Trauma Recovery Center



Impact



Served a total of **1,958** unique patients across a range of services.



Provided bedside support to more than **90** patients for behavioral health services and engagement with Cleveland Peacemakers for violence prevention.



Provided **9** professional development training sessions to extend trauma-informed practices throughout the community with Cleveland Metropolitan School District, Legal Aid Society of Cleveland, and others.

The **Trauma Recovery Center (TRC)** is dedicated to supporting trauma survivors, their families and hospital responders throughout the healing process by fostering safety, trust and strong connections.

In 2025, the TRC deployed trauma recovery coaches, a community education coach and peer support to provide essential resources, educate survivors about their rights and advocate for equitable access to healing services. This work is done at the hospital bedside, several community locations and in partnership with many community-based organizations.

SAFE (Students Are Free to Express) Project



Impact



Served **598** students, through **296** workshops, in **37** classrooms and **13** culminating celebrations.

Student Quotes

Participating in the SAFE Project workshops made me feel...

"Happy and able to be myself."

"Inspired and motivated and happy."

"Better than before."

The **SAFE Project** is an arts-based, psychologically informed program created to foster resilience in urban youth who have been exposed to chronic stressors, including individual and community trauma. The **Center for Arts in Health and School Health Program** partnered with grades 9-12 in Glenville High School, Lincoln West School of Science & Health and six community arts organizations to deliver the award-winning program.

In addition to the arts residencies, the program trains teaching artists and partner teachers to ensure trauma-responsive practices are sustained, and student engagement continues to grow.

Community Health Workers



Impact



3,718 primary care patients supported through **5,464** outreaches



Responded to **2,400** requests for assistance from patients



656 referrals to CHWs from clinical care team

We developed an innovative model to integrate **Community Health Workers** (CHW) in our primary care clinics. This has enhanced our capacity for social needs navigation, particularly expanding reach across clinics serving high-need populations.

CHWs partner with patients during appointments or through provider referrals to identify unmet needs related to food access, transportation, housing stability, insurance navigation, utilities support and financial strain. Through a relationship-based approach, CHWs provide personalized follow-up, education, advocacy and coordinated referrals that help patients overcome barriers to chronic disease management and improve engagement in their care.

Community Engagement, Education and Evaluation

As a leader in efforts to address the social drivers of health, the Institute for H.O.P.E. is committed to maintaining an external presence through broad dissemination of our work and active engagement in the community.

In 2025, we:

11

Conducted **11** presentations at national and regional conferences.

5

Published **5** scholarly journal articles.

3

Received **3** awards that recognize our leadership and contributions to the community.

4

Contributed to **4** external media pieces that highlight the significance of SDOH.

79

Participated in **79** community events.

Funding Highlights



In July 2025, the **Ohio Arts Council** awarded a four-year sustainability grant to MetroHealth's Center for Arts in Health, to support the continued integration of the arts in programs for patients, caregivers and the community. MetroHealth will receive **\$38,456** in the first year.



In December 2025, **KeyBank Foundation** awarded a three-year grant of **\$1.5 million** in support of the Opportunity Centers in Buckeye and Clark-Fulton neighborhoods. This funding builds on MetroHealth's efforts to expand collaboration with the communities we serve while addressing the social drivers that impact our patients by fostering partnerships and improving access to needed resources.



For the tenth consecutive year, our Trauma Recovery Center (TRC) received more than **\$540,000** as part of Ohio Attorney General Dave Yost's allocation of federal funding from the **Victims of Crime Act (VOCA)**. This funding allows the TRC to continue its nationally recognized work to support survivors of violence and their families through trauma recovery coaching, peer mentorship, victim advocacy and counseling.

Institute for H.O.P.E. 2025 Donors and Grantors

Thank you, donors and grantors! The following individuals and organizations provided generous support to help make our work possible. Those listed below contributed \$5,000 or more in 2025.

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The CIGNA Corporation

The Cleveland-Cliffs Foundation

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