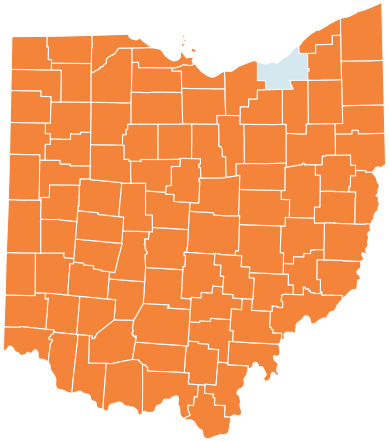
2019

Cuyahoga County Community Health Implementation Strategy



School of Medicine, Case Western Reserve University

cdph Cleveland Department of Public Health

Cuyahoga County Board of Health
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HIP Cuyahoga Health Improvement Partnership

The Center for Health Affairs

University Hospitals

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2019 Cuyahoga County Community Health Implementation Strategy
Adopted by University Hospitals on March 20, 2019.

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- http://hipcuyahoga.org/2018cha/
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- www.UHhospitals.org/CHNA-IS

We welcome comments and feedback on ways to improve this document in future editions. We can be reached at 216-309-CHIP(2447) or hip.cuyahoga@gmail.com

Written Comments

Individuals are encouraged to submit written comments, questions, or other feedback about University Hospitals' strategies to communitybenefit@UHhospitals.org. Please make sure to include the name of the UH Facility that you are commenting about, and if possible, a reference to the appropriate section within the Implementation Strategy.

2019 Cuyahoga County Community Health Implementation Strategy

Adopted by University Hospitals Board of Directors March 20, 2019.

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Introduction

In 2018, University Hospitals Ahuja Medical Center, Beachwood RH, LLC (UH Rehabilitation Hospital), UH Regional Hospitals (Bedford and Richmond Campuses), University Hospitals Cleveland Medical Center, The Parma Community General Hospital Association d/b/a University Hospitals Parma Medical Center, University Hospitals Rainbow Babies & Children's Hospital, and University Hospitals St. John Medical Center (collectively the "Hospitals") developed a combined assessment with Case Western Reserve University School of Medicine, the Cleveland Department of Public Health, the Cuyahoga County Board of Health, the Health Improvement Partnership-Cuyahoga, and The Center for Health Affairs. This assessment, the 2018 Cuyahoga County Community Health Assessment - a Community Health Needs Assessment ("CHNA"), was the first combined assessment of its kind in Cuyahoga County and represents a new, more effective and collaborative approach to identifying and addressing the health needs of the community at the local level while enabling these stakeholders to align with state plans. This work sets the stage for an even larger collaborative assessment effort planned for 2019 that engages additional health care systems in Cuyahoga County. The assessment was approved by the University Hospitals Board of Directors on September 27, 2018.

The recent 2018 CHNA, compliant with the requirements of Treas. Reg. §1.501(r) ("Section 501(r)"), served as the foundation for developing an Implementation Strategy ("IS") to address those needs that, (a) the Hospitals determine they are able to meet in whole or in part; (b) are otherwise part of UH's mission; and (c) are not met (or are not adequately met) by other programs and services in the county.

This report, the 2019 Cuyahoga County Community Health Implementation Strategy, serves as the initial IS – a bridge year -- to move the Hospitals into a more collaborative approach with public health departments and other county partners. While public health partners were not required to complete a 2019 Cuyahoga County Community Health Implementation Strategy, which they define as an Improvement Plan, they have worked collaboratively with the 8 University Hospital facilities located in Cuyahoga County to develop one aligned strategy to address a shared health priority. This demonstrates the intent of public health partners and University Hospitals to collaborate not just in developing joint CHNAs, but also in addressing health needs through more effective community health planning. This work will continue for the next planning cycle, which will engage additional health care systems in Cuyahoga County, beginning in 2019.

This IS, also required by Section 501(r), documents the Hospitals' efforts to address the community health needs identified in the 2018 CHNA. The IS identifies the means through which the Hospitals' plan to address a number of the needs that are consistent with UH's charitable mission during 2019 as part of its community benefit program.

The Hospitals anticipate that the strategies may change and therefore, a flexible approach is well suited for the development of its response to the 2018 CHNA. Other community organizations may address certain needs or new opportunities for collaboration may be identified, all of which may lead to modification to the IS.

Additionally, Ohio Revised Code ("ORC") 3701.981 (effective September, 2016), mandated that all tax-exempt hospitals must collaborate with their local health departments on community health assessments (a "CHA") and community health improvement plans (a "CHIP"). Local hospitals must also align with the State Health Assessment (a "SHA") and State Health Improvement Plan (a "SHIP") for the state of Ohio; details are available in Appendix 1.

Note: This symbol will be used throughout the report when a priority, indicator, or strategy directly aligns with the 2017-2019 SHIP.

The alignment of the CHNA and IS pertains to the process, timeline, indicators, and strategies. This local alignment must take place by October 2020.

University Hospitals Health Systems, Inc. ("University Hospitals" or "UH"), contracted with The Center for Health Affairs ("The Center") and Cypress Research Group ("Cypress") to develop the IS. The Center and Cypress guided the process and together with the Hospitals reviewed primary data, hospital utilization and discharge data, and evaluation of program impact reports from the 2018 CHNA as well as the prior IS reports from 2016. The goal was to identify strategies to address the priorities identified in the 2018 CHNA.

The following priorities were identified:

- Poverty
- Opioids / substance use disorders / mental and behavioral health
- Infant mortality
- Homicides / violence / safety
- Chronic disease management and prevention.

These priorities align closely with the priorities in the Ohio SHIP.

Cleveland Department of Public Health Mission Statement

We are committed to improving the quality of life in the City of Cleveland by promoting healthy behavior, protecting the environment, preventing disease and making our communities healthy places to live, visit, work and play.

Cuyahoga County Board of Health Mission Statement

To work in partnership with the community to protect and improve the health and well-being of everyone in Cuyahoga County.

Hospital Mission Statement

As a wholly owned subsidiary of University Hospitals, the Hospitals are committed to supporting the UH mission, “To Heal. To Teach. To Discover.” (the “Mission”), by providing a wide range of community benefits including clinical services, medical education and research. UH is an integrated delivery system and thus can provide benefits by coordinating within and among various entities (“UH System”).

2018 CHNA Observations

The 2018 Cuyahoga County Community Health Assessment is a 277-page report that consists of primary and secondary data for Cuyahoga County. The following data are key findings from the CHNA that deepened our understanding of the current health needs and health inequities in our community and support the priorities and strategies found in this IS. The full CHNA report can be found at: https://www.uhhospitals.org/about-uh/community-benefit/community-health-needs-assessment

1. **The strongest indicator we have of health status is poverty.** The 2018 Cuyahoga County Community Health Assessment identified several inequities in access to care and health outcomes based on socioeconomic status:
    a. One-third (35%) of city of Cleveland residents lived below the poverty line in 2016, compared to half that (18.1%) of county residents, as a whole.
    b. Likewise, Cleveland residents were significantly more likely to die of cardiovascular disease (+27.5%), a drug-induced death (+64.3%) or to be a homicide victim (+99.3%).

2. There are several priority health and safety concerns for Cuyahoga County and there are several reasons for this designation. They may be conditions where Cuyahoga County appears to compare unfavorably to its peer counties, they may be conditions that can be minimized or prevented via effective programming, or they may have been selected because they impact certain population groups in our county at particularly high frequency. For all of these, Cuyahoga County compares unfavorably to national benchmark goals in the following areas:

    a. Cuyahoga County's mortality rate from **cardiovascular disease** was significantly higher (199.8 per 100,000) than for the U.S. overall (165.5) and the national benchmark of 100.8. Cardiovascular disease was also the most common reason for hospitalizations in Cuyahoga County in 2016.

    b. Cuyahoga County's **suicide rate** is two points above the national benchmark of 10.2 (per 100,000). In surveys, county residents report an average of 3.7 **poor mental health days** per month. The **homicide rates** within Cuyahoga County (14.2) and the city of Cleveland (28.3) are significantly higher than the national benchmark of 5.5 (per 100,000).

    c. **Infant mortality** rates in Cuyahoga County (8.7 per 1,000) and the city of Cleveland (12.0) are also significantly higher than for the U.S. overall (5.9) and the national benchmark (6.0). Furthermore, the county rate is three times higher for Black, non-Hispanic infants (15.0) compared to White, non-Hispanic infants (4.5).

    d. **High blood lead levels** among young children (ages 5 and younger) are a persistent problem. For Cuyahoga County residents under age 6, 8.2% had dangerous blood lead levels (> 5 ug/dl) in 2016, and that was significantly higher for young children in the city of Cleveland (12.4%). This compares very unfavorably to the state (2.0%) and national rate (3.0% in 2015) overall. Blood lead levels above zero are considered above the national benchmark.

    e. The number of **unintentional opioid deaths** was high in Ohio overall (32.9 per 100,000), but somewhat higher in Cuyahoga County (38.2). In the city of Cleveland, the rate of unintentional opioid deaths is about twice as high (61.8) as in the county overall. The rate of unintentional opioid deaths in the city of Cleveland is about five times that of the U.S. overall (13.3).

    f. Many of the estimated 20,000 or more deaths in the U.S. from influenza each year may have been prevented by the flu vaccine. The national benchmark for vaccination levels among

Medicare beneficiaries is 70%. Within Cuyahoga County during the 2017-2018 flu season, only 48.9% **received a flu vaccine**.

g. **Tobacco (cigarette) use in Cuyahoga County is higher than the national rate (21% vs. 15.5%).** City of Cleveland residents use cigarettes at a much higher rate (35.2%). Of particular concern is the higher incidence of mothers who smoked during pregnancy (U.S. overall, 7.2%; Cuyahoga County, 9.1%; city of Cleveland, 14.3%).

h. Within the city of Cleveland, **residents lack sufficient physical activity** at higher rates (58.1%) compared to the national benchmark (32.6%).

3. **Childhood asthma** was the most common ambulatory care sensitive (ACS) condition for hospitalized children in 2016, where the incidence of childhood asthma differed based on race and/or ethnicity. Significantly higher proportions of hospitalized Medicaid beneficiaries were Black (4.2%) or of Hispanic descent (3.3%) compared to White children (1.3%). **This suggests higher rates of childhood asthma among Black and Hispanic children and lower access to primary care to minimize hospitalizations.** We know that exposure to asthma triggers like dust mites and indoor pollutants associated with substandard housing and exposure to environmental tobacco smoke and outdoor air pollutants are risk factors for childhood asthma, and optimizing clinical care, improving the quality of housing, and reducing trigger exposure can reduce asthma exacerbations.

4. The most common ACS conditions for older adult residents of Cuyahoga County in 2016 were **chronic obstructive pulmonary disease** (4.6% of all adults age 40+ hospitalizations) and **congestive heart failure** (5.5% of all seniors hospitalized). Improved screening and primary care for these conditions can reduce hospitalization rates.

5. An examination of all hospitalized Cuyahoga County patients' diagnoses in 2016 shines a light on the impact of chronic health conditions as well as the complexity of most hospitalization cases. Most inpatients had multiple secondary diagnoses requiring a high level of coordinated care. The following are conditions that were far more common as secondary diagnoses than as primary diagnoses (in other words, patients' secondary diagnoses did not lead to the hospitalization, but greatly complicated the care needed during hospitalization):

    a. Hyperlipidemia (18.3%)
    b. Type 2 diabetes (16.5%)
    c. Essential hypertension (16.0%)
    d. Anemias (11.2%)
    e. Nicotine dependence (10.4%)
    f. Substance dependence/abuse (alcohol, opioids, cocaine, cannabis, etc., 8.2%)
    g. Hypertensive heart & kidney disease (8.0%)
    h. Gastro-esophageal reflux disease (6.9%)
    i. Chronic kidney disease (6.8%)
    j. Asthma (5.8%)
    k. Adverse effect/poisoning by prescribed or over-the-counter drugs (4.9%)
    l. Chronic pain (4.2%)
    m. Encephalopathy (4.2%)
    n. Dementia (3.6%)

The most common reason children are hospitalized differs from that for adults. Looking just at hospitalized Cuyahoga County patients under the age of 18 in 2016, excluding healthy newborns, the most common primary diagnosis was related to diseases of the respiratory system (23.0%) – whereas for adults diseases of the circulatory system were the most common reason for hospitalization. Asthma was the most common condition and was a primary diagnosis for 4.6% of patients and a secondary diagnosis for 12.8% of young patients. Hospitalizations related to mental and behavioral health disorders (12.2%) comprised the second largest category of primary diagnoses among patients under the age of 18. Digestive system diseases (7.3%) were the third most common category of primary diagnoses among young patients.

6. Evidence is growing that food insecurity due to poverty and lack of access to high-quality nutritious food leads to increased risk for chronic disease and poor health outcomes. A large proportion of the city of Cleveland is considered a “food desert,” where residents have limited local access to grocery stores and other sources of healthy food.

Priority Health Needs

Poor health status can result from a complex interaction of challenging social, economic, environmental and behavioral factors, combined with a lack of access to care, perceived or actually present. Addressing the more common "root" causes of poor community health can serve to improve a community's quality of life and to reduce mortality and morbidity.

Based upon review of the community voice, community stakeholder, hospital and secondary data contained within the 2018 Cuyahoga County Community Health Assessment, a list of the top 13 health issues were identified (Appendix 2). Many of the top health and safety concerns for Cuyahoga County were selected based on Cuyahoga County comparing unfavorably to peer counties and unfavorably to national benchmark goals. Some of the top health needs were chosen because certain population groups in Cuyahoga County experience these conditions at high rates.

A two-step process was used to arrive at the final list of five prioritized health needs. The first step involved assignment of priority points by each voting participant (which included hospital representatives from the 8 UH hospitals as well as both public health departments) to eliminate five health needs from the initial list of 13, to arrive at eight health needs. The second step involved each voting participant recording their ratings for each of the eight remaining health needs based on consideration of the following criteria: magnitude of the problem; severity of the problem; and magnitude of the health disparity. For both voting rounds, weighting was used to ensure that public health stakeholders received a combined 50% of the vote and hospital stakeholders received a combined 50% of the vote.

The following five health needs were selected as priorities that will be the focus of the IS. There is strong alignment between the selected health priorities and state population health priorities. In no particular order:

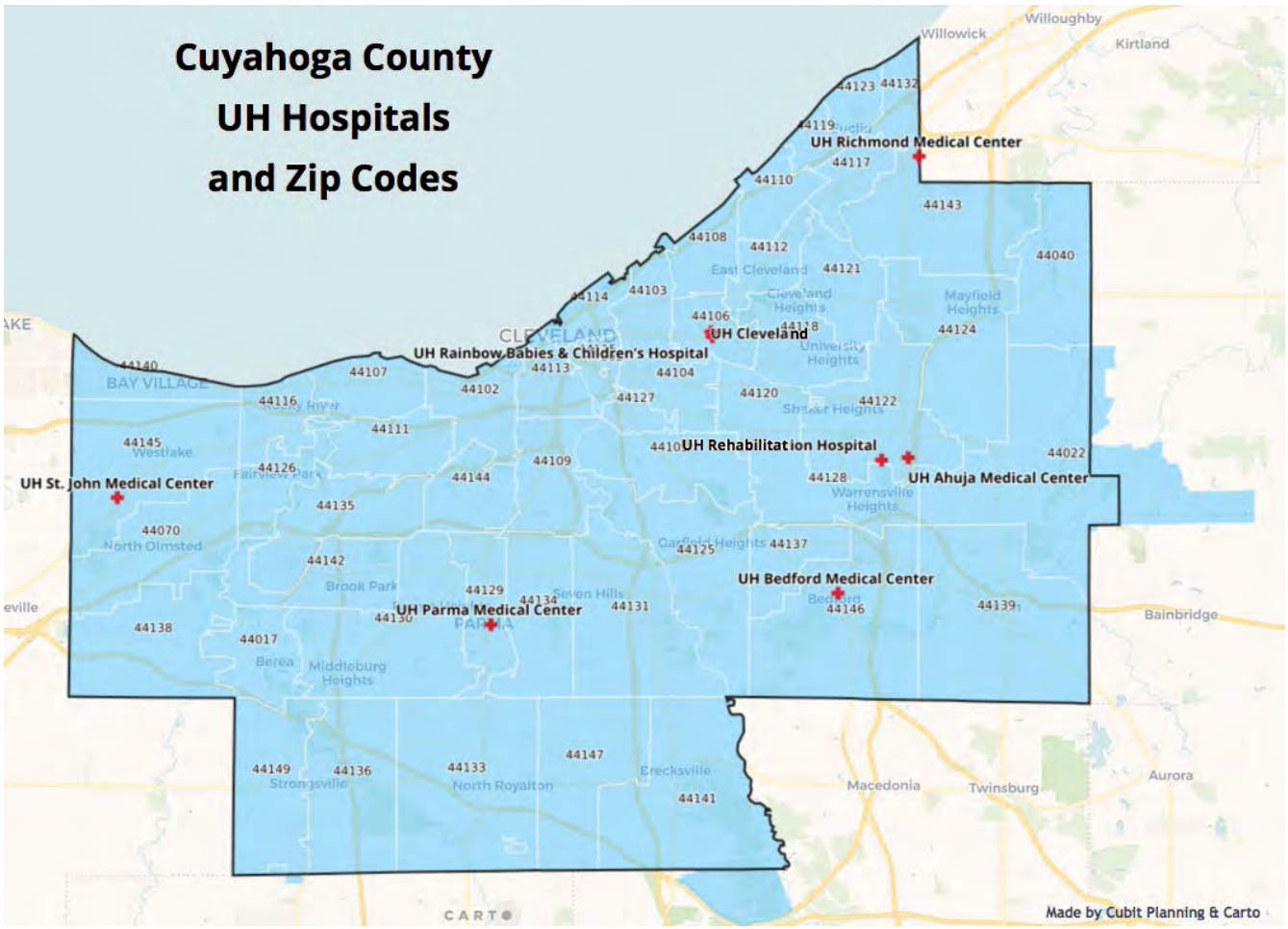
1) Poverty (i.e. healthy homes, food insecurity)
2) Opioids / Substance Use Disorders / Mental and Behavioral Health
3) Infant Mortality
4) Homicides / Violence / Safety
5) Chronic Disease Management and Prevention (i.e. cancer, diabetes, COPD, asthma, cardiovascular disease, healthy eating / active living)

Health Priority	UH Hospital Planning to Address	
Poverty	UH Ahuja Medical Center UH Bedford Medical Center UH Cleveland Medical Center UH Parma Medical Center UH Richmond Medical Center	
Opioids / Substance Use Disorders / Mental and Behavioral Health	UH Cleveland Medical Center* UH St. John Medical Center	
Infant Mortality	UH Rainbow Babies & Children's Hospital	
Homicides / Violence / Safety	UH Cleveland Medical Center	
Chronic Disease Management and Prevention	UH Ahuja Medical Center Beachwood RH, LLC (UH Rehab. Hosp.) UH Bedford Medical Center UH Cleveland Medical Center	UH Parma Medical Center UH Rainbow Babies & Children's Center UH Richmond Medical Center UH St. John Medical Center

*UH Cleveland Medical Center activities that address this health priority are reflected on page 51.

Community Served by University Hospitals

The community has been defined as Cuyahoga County for eight University Hospital (UH) facilities that are located in Cuyahoga County and have the majority of their patient discharges from Cuyahoga County: UH Ahuja Medical Center, Beachwood RH, LLC (UH Rehabilitation Hospital), UH Bedford Medical Center, UH Cleveland Medical Center, UH Parma Medical Center, UH Rainbow Babies & Children's Hospital, UH Richmond Medical Center and UH St. John Medical Center. Defining the community in this way allows the health care system to more readily collaborate with public health partners for the completion of community health needs assessments, and health improvement planning based on shared geographical communities served and health priority.



Strategies to Address Health Needs

University Hospitals

For the 2019 IS, each UH hospital team met to identify potential strategies to execute in view of lessons learned and current opportunities. To do this, the teams reviewed various sources of data including primary data, hospital utilization and discharge data, and evaluation of program impact reports from the 2018 CHNA as well as the prior IS from 2016. The teams built upon the efforts of the previous IS. Additionally, all eight hospitals, both public health departments, medical residents from Case Western Reserve University School of Medicine and local community stakeholders met to identify a collective strategy involving all partners and to receive general input from community representatives. The following strategies, goals and objectives were developed.

Note: This symbol  *will be used throughout the report when a priority, indicator, or strategy directly aligns with the 2017-2019 SHIP.*

University Hospitals
Ahuja Medical Center

STRATEGIES

UH Ahuja Medical Center

University Hospitals Ahuja Medical Center, which opened in 2011, is a 144-bed community hospital focused on patient and family-centered care and the principles of evidence-based design. It is designed to be one of the safest and most technologically advanced hospitals in the country. Built on a calm, park-like campus that includes gardens and walkways, the hospital provides exceptional care to residents of Cuyahoga, Lake and Summit counties.

UH Ahuja Medical Center's medical staff includes over 980 physicians and allied professionals highly trained in 21 full-service specialties and subspecialties including adult and pediatric emergency services, cardiology, neurosurgery, pulmonology, orthopedics and more.

University Hospitals Ahuja Medical Center
CHNA Priority: **Chronic Disease Management and Prevention**
Strategy 1: • Community engagement to provide education, screening and support groups to prevent and/or manage chronic diseases
Goals: • Reach people/communities with limited access to valuable health information • Increase knowledge about chronic diseases in general, including prevention and disease management strategies • Increase early detection of diseases
Objectives: • Provide or participate in at least 40 educational and/or screening events in the community: o Corporations, YMCA, schools, temples, churches, senior centers, low income apartments, community health fairs and rehab centers o Involvement in eight community Chambers of Commerce offering health education and screening to their members and companies • Offer education talks, support groups and connection to resources to at least 3,800 people via: o 4 diabetes management classes (Target: 50 people annually) o Monthly support group for diabetic patients (Target: 20 people) o Monthly Wellness Seminars with presenting physicians and auxiliary staff o Monthly talks for Emergency Medical Services o Family Health and Safety Day at Ahuja with screenings for vascular, biometric, carotid, dermatology, BMI and orthopedic issues o Women's Health Expo with educational speakers and biometric screening o Ortho Day with orthopedic surgeon speakers, rehabilitation, diabetes, pain management, pharmacy and home care dialogue and information • Conduct screenings with at least 2,500 people via events at corporations, YMCA, schools, temples, churches, senior centers, low income apartments, community health fairs and rehabilitation centers o Develop a program with Food Strong CLE for health screenings and educational materials to be provided during Farmers Markets

- Hernia screening with the ability to follow up with further testing and appointments with surgeons. Screenings typically include: blood pressure, cholesterol, A1C

Anticipated Outcomes:

- Increased connection to primary care physicians, specialists and surgeons if needed
- Improved health outcomes for individuals participating in classes and support groups; reduced A1C blood test results for diabetic patients
- Reduced complications and hospitalizations due to early detection and improved management of diabetes, heart disease, and respiratory failure for individuals participating in classes and support groups
- Continue increasing number of follow-up screenings scheduled
- Increased number of appointments scheduled with primary care provider in reaction to positive screenings
- Improved medical screening results for disease management group participants (e.g. A1C levels for diabetics)

Indicators used to measure impact of outcomes:

- Proportion of adults who have been told by a health professional that they have diabetes or prediabetes *(Source for Data: BRFSS, vs. 2019 baseline)*
- Proportion of adults who engage in Type II diabetes prevention behaviors (exercise, controlled diet, controlled weight) *(Source for Data: BRFSS, vs. 2019 baseline)*

Collaboration and Partnerships:

- Local corporations, YMCA, schools, temples, churches, senior centers, low income apartments, rehabilitation centers, Chamber of Commerce

University Hospitals Ahuja Medical Center

CHNA Priority: **Poverty**

Strategy 2:

- UH Ahuja has had great success in building strong relationships with area employers in order to use employer locations for screening events. Upon review of where events tend to be held, outreach personnel identified areas of the community where the outreach was not reaching certain types of community members, in particular very low income families. A new annual event was thus designed, with the goal of targeting the most under-resourced community members. This event, Breakfast with Santa, will be launched in connection with the Warrensville Heights YMCA.

Goals:

- To provide an event that supports children and families that are marginalized in the area. Outreach thru local YMCA programming, local daycares, preschools, schools, the human resource department at UH Ahuja Medical Center and community social workers.

Objectives:

- To provide an event on December 14, 2019 that is a celebration of community and Santa, along with a nutritional meal, engagement in arts and crafts, literacy program with reading and a book to take home, and gifts of school backpacks filled with school supplies. Certificates for Swim and Water Safety lessons to be given to the children
- Developing strategies to include more community partners in 2019

Anticipated Outcomes:

- Develop an event which targets and attracts community members whose access to healthcare and health information is most constrained and use this event to build awareness of services available to them, share important health information which impacts them, and identify specific needs of these community members related to their health.
- To increase community awareness of the children in the Warrensville Heights and the Tri city area who are in need.
- Evaluation of the program with the Executive Board of the YMCA to ensure targeted annual participation levels of the target population
    - Goal is to reach approximately 200 to 300 children within the most under-resourced areas of the community
    - Include more community partners to expand the scope of services and information brought to event participants

Indicators used to measure impact of outcomes:

- Decreased number of community members without any health insurance *(Source for Data: BRFSS, vs. 2019 baseline; Census Bureau, ACS estimates, 2019 baseline)*
- Decreased use of Emergency Department for non-emergent medical issues *(Source for Data: UH)*
- Increased proportion of community members in the most under-resourced areas with a medical home *(Source for Data: BRFSS, aggregated for key zip codes)*

Collaboration and Partnerships:

Warrensville Heights YMCA; communities of Nordonia Hills, Warrensville Heights and Highland Hills; Sodexo; Amazon Corporation; NSL Analytical Corporation; and area business and community leaders.


University Hospitals
Rehabilitation Hospital
A Joint Venture with Kindred Healthcare

STRATEGIES

Beachwood RH, LLC (UH Rehabilitation Hospital)

UH Rehabilitation Hospital is a joint venture between University Hospitals and Kindred Healthcare Corporation. It aides in restoring lives, helping patients regain their independence so they can return home. It is a 50-bed, state-of-the-art acute inpatient rehabilitation hospital dedicated to the treatment and recovery of individuals who have experienced a variety of conditions including amputation, brain injury, neurological conditions, orthopedic injury, spinal cord injury, stroke and trauma. It provides acute inpatient medical and functional rehabilitation.

Beachwood RH, LLC (UH Rehabilitation Hospital)
CHNA Priority: **Chronic Disease Management and Prevention**
Strategy 1: • To improve awareness and education about strokes for the local community that we serve.
Goals: • Increase awareness of stroke and stroke prevention. • Create monthly support group for stroke survivors and caregivers
Objectives: • Offer monthly stroke support group for stroke survivors and care givers to improve their ability to manage their own care or provide stroke care to others • Provide education at local events (i.e. Big Tent, Healthy Wellness days, etc.)
Anticipated outcomes: • Offering a venue to stroke survivors and caregivers where they can gain support and state-of-the art knowledge about stroke care and services for them in our community. • Create enhanced education on stroke prevention and reduce the number of strokes in the local community • Attendance at stroke group o Target participation levels: 8 events for stroke survivors group; 4 events for caregivers support group • Number of educational materials distributed • Attendance at community events o Target participation levels: 150 attendees at Big Tent; 100 attendees at Healthy Wellness days • Number of speaking engagements for stroke experts **Indicators used to measure impact of outcomes:** • Reduced length of initial hospital stay for those with a primary diagnosis of stroke *(Source for Data: OHA or UH)*
Collaboration and Partnerships: Partnership with UH hospitals (UH Ahuja, UH Bedford and UH Richmond); American Diabetes Association; Cuyahoga County Board of Health; physicians and physical therapists.

Beachwood RH, LLC (UH Rehabilitation Hospital)

CHNA Priority: **Chronic Disease Management and Prevention**

Strategy 2:

- To improve community members' understanding of risk factors associated with diabetes, and awareness of diabetes prevention and management.

Goals:

Bring UH resources to the outside community for those previously not reached:

- Provide pre-screens, offer educational materials, participate in local community events, and provide access to physicians.

Objectives:

- Provide community outreach while improving the number of individuals who have early detection of diabetes.

Anticipated Outcome(s):

- Increase number of individuals who have early detection and provide access to physicians.
  - During the course of the year 200 people receive early detection
  - During the course of the year 25 receive access to physicians
- Increased number of individuals who participated in screens; number of positive screenings requiring some kind of follow-up; and number of educational materials distributed to community members.

Indicators used to measure impact of outcomes:

- Proportion of adults who have been told by a health professional that they have diabetes or prediabetes *(Source for Data: BRFSS, 2019 baseline)*
- Proportion of adults who engage in Type II diabetes prevention behaviors (exercise, controlled diet, controlled weight) *(Source for Data: BRFSS, 2019 baseline)*

Collaboration and Partnerships:

Partnership with UH hospitals (Bedford, Richmond, and Ahuja); American Diabetes Association; local support groups and physicians.


University Hospitals
Bedford Medical Center
Richmond Medical Center
Campuses of UH Regional Hospitals

STRATEGIES

UH Bedford Medical Center and UH Richmond Medical Center (UH Regional Hospitals)

For more than 90 years, University Hospitals Bedford Medical Center, a campus of UH Regional Hospitals, has served the residents of Bedford, Ohio and the surrounding communities. It is a full service, acute-care community hospital, offering adult and senior emergency services, a state-of-the-art outpatient surgery center, comprehensive imaging facilities and a network of primary and specialty care physician practices.

UH Bedford Medical Center's medical staff includes 193 physicians highly trained in 30 medical specialties, including orthopedics, ophthalmology, wound care and hyperbaric medicine, geriatric medicine and more. It is a certified Primary Stroke Center and an accredited Chest Pain Center. It also holds NICHE Exemplar status - the highest designation available by the nursing education program, Nurses Improving Care for Healthsystem Elders (NICHE).

University Hospitals Richmond Medical Center, a campus of UH Regional Hospitals, is a 59-staffed-bed acute-care hospital serving the residents of Lake and eastern Cuyahoga counties since 1961. UH Richmond Medical Center includes adult and senior emergency services, comprehensive imaging facilities, a dedicated wound care center, and a network of primary and specialty care physician practices. It is also a premier location for UH Center for Lifelong Health and Age Well Be Well, a popular club for seniors.

UH Richmond Medical Center's medical staff consists of more than 190 UH and independent physicians representing over 30 medical specialties. The hospital is a certified Primary Stroke Center and an accredited Chest Pain Center. It also holds a Senior Friendly designation from the nursing education program, Nurses Improving Care for Healthsystem Elders (NICHE).

The same implementation strategies will be happening at both hospitals.

University Hospitals Bedford Medical Center & Richmond Medical Center

CHNA Priority: **Chronic Disease Management and Prevention**

Strategy 1:

- Provide 1) screenings and 2) health / disease education to detect and help manage chronic disease

Goal:

- Reduce incidence of chronic disease, hospitalization rates and mortality due to chronic diseases (i.e. diabetes, cardiac, pulmonary) in our communities

Objectives:

- Provide education about chronic disease detection and management in a variety of community venues (i.e. wellness events, lectures, distribution of literature, etc.), reaching at least 150 people at each hospital, total of 300 individuals
- Provide screenings that detect disease processes (200 at each hospital, total of 400)
- Provide access to healthcare professionals who will help manage chronic diseases
- Provide support groups for individuals with chronic conditions

Anticipated Outcomes:

- Increased number of community outreach events to counsel/screen a broader number and type of community members
- Improved proportion of community members whose chronic disease is screened for and detected early in the disease progression.
- Improved number of individuals educated about the more pervasive chronic diseases in our community
- Improved number of individuals screened for cardiac, pulmonary and diabetes conditions

Indicators used to measure impact of outcomes:

- Proportion of adults who have been told by a health professional that they have diabetes or prediabetes, cardiac or pulmonary disease in the past year
- Proportion of adults who engage in chronic disease prevention or control prevention behaviors (i.e. exercise, controlled diet, controlled weight, regular visits to health care professional)

Collaboration and Partnerships:

Health professionals- dieticians, physicians, nurse practitioners, EMS institute, respiratory therapists; community partnership on aging; local churches; local nursing facilities; local senior centers; local government; local businesses; Cuyahoga County Public Library; educational institutes; and local schools

University Hospitals Bedford Medical Center & Richmond Medical Center

CHNA Priority: **Poverty**

Strategy 2:

- Financial constraints are a common barrier to accessing needed healthcare. During non-emergent visits to the Emergency Department, low-income individuals will receive education about better health care service utilization, financial counselling services from hospital financial specialists and support services from third party vendors. These vendors connect people with healthcare insurance that is appropriate for their medical needs and level of income, i.e. Medicaid applications, insurance from the exchanges, or whatever is appropriate for their situation.

Goal:

- Ensure that community members seek necessary healthcare services when needed to prevent worsening conditions and need for higher cost services.

Objectives:

- Educate community members on proper use of emergency department and financial counselling services available

Anticipated Outcomes:

- Increased primary care alignment
- Increased number of individuals seeking services when needed
- Increase in insured lives in our communities
- Increase in number of events where education is available
- Increased number of individuals educated at talks/lectures about this topic

Indicators used to measure impact of outcomes:

- Decreased number of community members without any health insurance *(Source for Data: BRFSS, vs. 2019 baseline; Census Bureau, ACS estimates, 2019 baseline)*
- Decreased use of Emergency Department for non-emergent medical issues *(Source for Data: UH)*
- Increased proportion of community members in the most under-resourced areas with a medical home *(Source for Data: BRFSS, vs. 2019 baseline)*

Collaboration and Partnerships:

Third party vendors; internal UH departments including financial counselling staff, ED providers and staff, primary care offices

University Hospitals
Cleveland Medical Center

STRATEGIES

UH Cleveland Medical Center (CMC)

Founded in 1866, University Hospitals Cleveland Medical Center has a long history of providing exceptional healthcare for the residents of Northeast Ohio. Among the nation's leading academic medical centers, UH CMC is leading the way in both the discovery and implementation of medical advancements and the delivery of exceptional patient care.

With more than 1,000 registered beds, UH CMC provides primary, specialty and subspecialty medical and surgical care. Located in the heart of Cleveland's University Circle on a beautiful 35-acre campus, UH CMC includes general medical, intensive care and surgical units as well as two major hospitals:

- UH Seidman Cancer Center
- UH Rainbow Babies & Children's Hospital

As a comprehensive, integrated, academic health system, its physicians and researchers span the full spectrum – from basic/translational to clinical/population research. The UH Clinical Research Center is home to the largest clinical trial site in northeast Ohio with more than 1,000 active trials.

University Hospitals Cleveland Medical Center
Neurological Institute
CHNA Priority: **Chronic Disease Management and Prevention**
Strategy 1: • Reduce the incidence of cardiovascular disease by improving the level of state-of-the-art stroke care education among nursing and ancillary clinical staff for the Northeast Ohio region; including non-UH employees
Goal: • Provide stroke education at Neuroscience Nursing Symposium on September 26, 2019.
Objective: • Review current guidelines on the diagnosis, treatment and care of patients with cerebrovascular disorders based on the latest advances in the fields of neurology, neurosurgery, neuro-interventional, neuro-critical care, and neuroscience nursing
Anticipated Outcome: • Attendance of 150 or more participants including nurses, therapists and other ancillary clinical staff within the Northeast Ohio region.
Indicators used to measure impact of outcomes: • Reduced length of initial hospital stay and inpatient rehabilitation stay for those with a primary diagnosis of stroke *(Source for Data: UH)*
Collaboration and Partnerships: Internal UH departmental collaboration

University Hospitals Cleveland Medical Center
Neurological Institute
CHNA Priority: **Chronic Disease Management and Prevention**
Strategy 2: • Community stroke education developed to reduce the incidence of cardiovascular disease – 3 stroke risk screening sessions will be provided in May 2019 during stroke awareness month. The screening will be conducted by nurses and will include blood pressure assessment, BMI assessment, review of medical history for stroke risk factors and education. Education will include: signs of stroke, calling EMS emergently, interventions to control risk factors, healthy diet and exercise discussions and the importance of regular physician checkups and medication compliance. Written materials.
Goal: • Provide stroke education at stroke risk screening events
Objective: • Improve public recognition of stroke symptoms and stroke risk factors
Anticipated Outcomes: • Increase number of at-risk community members' knowledge of controlling stroke risk factors to prevent a stroke • Screen 300 or more participants total over the 3 days • Increase number of patients calling EMS for stroke symptoms
Indicators used to measure impact of outcomes: • Reduced length of initial hospital stay and inpatient rehabilitation stay for those with a primary diagnosis of stroke *(Source for Data: UH)*
Collaboration and Partnerships: Internal UH departmental collaboration

University Hospitals Cleveland Medical Center
Harrington Heart and Vascular Institute
CHNA Priority: **Chronic Disease Management and Prevention**
Strategy 3: • Awareness building and early detection
Goal: • Reduce the incidence of cardiovascular disease through prevention and early detection
Objectives: • Host 50 physician talks and/or screening events in strategic locations to reach under-resourced populations • Screen 1,000 or more people for cardiovascular disease and provide information about their results • Educate 2,000 or more people regarding vascular disease, cardiovascular risk factors and lifestyle, medication adherence, CPR, AED, and smoking/vaping cessation/education
Anticipated Outcomes: • Increased knowledge about risks and warning signs amongst at-risk populations • Increased number of people aware of risk factors and resources to address cardiovascular disease **Indicator(s) used to measure outcomes:** • Increased proportion of community-members who live in the most under-resourced communities who have had basic cardiovascular disease screening (blood pressure, etc.) within the past year *(Source for Data: BRFSS, vs. 2019 baseline)*
Collaboration and Partnerships: American Heart Association, Breakthrough Schools, Cuyahoga Metropolitan Housing Authority, Hunger Network, Ursuline College

University Hospitals Cleveland Medical Center
Harrington Heart and Vascular Institute
Priority: Chronic Disease Management and Prevention
Strategy 4: • Heart Failure CPR / safety training
Goal: • Increase the number of first responders trained in CPR and use of AED equipment
Objectives: • Offer trainings in local schools and business to increase awareness for sudden cardiac arrest and heart failure education and risks (Target: 3000 individuals)
Outcome: • Increased number of people trained in properly doing CPR/AED
Indicator: • Number of sudden cardiac victims who are admitted to the hospital from the Emergency Department *(Source for Data: UH, OHA)* • Average length-of-stay for sudden cardiac victims *(Source for Data: UH, OHA)* • Survival rates for hospitalized sudden cardiac event patients *(Source for Data: UH, OHA)*
Collaboration and Partnerships: Local first responder departments; UH EMS Institute

University Hospitals Cleveland Medical Center
Harrington Heart and Vascular Institute
Priority: Chronic Disease Management and Prevention / Poverty
Strategy 5: • Prepare the future workforce for careers related to heart-health
Goal: • Introduce middle school age youth to health professions • Increase knowledge about healthy behaviors
Objectives: • Offer classes at Cuyahoga Metropolitan Housing Authority weekly and Breakthrough schools twice a week and/or community based youth programs • Increase awareness about health professions and healthy lifestyles of students (Target: approximately 1,000 students)
Outcomes: • Increased awareness about health careers • Students have an increased interest in Sciences • Students apply for internships or shadowing experiences at hospitals • Improved awareness of risk factors, medication adherence, CPR training, AED training, and smoking cessation (CHMA) • Early education on cardiovascular risk factors and lifestyle, and smoking/vaping education
Indicator: • Decreased proportion of those aged 12-15 who use tobacco products *(Source for Data: YRFSS, vs. 2019 baseline)*
Collaboration and Partnerships: Breakthrough Schools, Cuyahoga Metropolitan Housing Authority, American Heart Association: STEM Goes Red for Girls

University Hospitals Cleveland Medical Center
UH Seidman Cancer Center
CHNA Priority: **Chronic Disease Management and Prevention**
Strategy 6: • Cancer risk reduction strategies targeted at under-resourced community members
Goal: • Increase cancer risk reduction awareness as it relates to breast and colon cancer
Objective: • Provide education and screenings to 1,400 participants • Host and/or participate in 50 screening and education events
Anticipated Outcome: • 3% increase in screenings compared to last year • Pre- and post- tests following educational presentations that indicate willingness to get screened **Indicators used to measure impact of outcomes:** • Improved early-stage cancer detection among under-resourced community members *(Source for Data: UH)* • Improved cancer survival rates *(Source for Data: CDC, at the county level)*
Collaboration and Partnerships: Cleveland Public Health Department; City of Cleveland; Cleveland Clinic Foundation; The MetroHealth System

University Hospitals Cleveland Medical Center
UH Seidman Cancer Center
CHNA Priority: **Chronic Disease Management and Prevention**
Strategy 7: • Increase access to cancer-related information and enhance health literacy
Goals: • To ensure that individuals have access to, and comprehend, materials pertaining to cancer. • To engage and practice health literacy principles that result in patient education materials and communication that are understood by all.
Objectives: • Publicize the Seidman Cancer Center learning library via 10 media outlets • Serve 800 library visitors • Examine and develop content for 15 publications to make them easy to understand • Provide a space and librarian to assist with identifying cancer-related information
Anticipated Outcome: • Increased health literacy • Increased access to useful information • Increased compliance to treatment • Increased visits to Seidman Cancer Center learning center **Indicators used to measure impact of outcomes:** • Improved five-year cancer survival rates *(Source for Data: CDC, at the county level)*
Collaboration and Partnerships: Cleveland Public Health Department; City of Cleveland, Health Improvement Partnership-Cuyahoga; Healthy CLE

University Hospitals Cleveland Medical Center

Adult Trauma Program, Violence Interrupters Program

CHNA Priority**: Homicides / Violence / Safety**

Strategy 8:

- Pilot a hospital and community-based partnership with Peacemakers Alliance in an attempt reduce gun-related violence in the target population. Peacemakers Alliance is housed within the Boys and Girls Clubs of Cleveland; it employs community-based outreach workers to provide mediation, conflict resolution, case management, family services and hospital-based intervention following violent incidents. For the latter, its focus is on preventing retaliation violence.

Goals:

- Provide intervention in the hospital with follow-up community-based referral and programs to victims of gun violence.
- Provide intervention to family and community members while the patient is hospitalized to reduce the potential of retaliatory violence.

Objectives:

- Introduction of Violence Interrupter services from Peacemakers Alliance in April 2018 to eligible victims of gun violence during hospitalization.
- Referral to outpatient community services, education and job placement at the time of discharge.

Anticipated Outcome:

- Increased number of victims of penetrating violence or their family members who receive violence intervention support services
- All gun violence victims and family members are offered intervention (includes community presence) to mitigate the potential for violence while victim is hospitalized

Indicators used to measure impact of outcomes:

- Reduced penetrating trauma violence in residents of Cleveland with a primary focus in the 16 to 30 year-old population *(Source for Data: City of Cleveland)*
- Reduction in recidivism (annualized tracking to be reported Q1 2020) *(Source for Data: UH and City of Cleveland)*

Collaboration and Partnerships:

Cleveland City Council; United Way; Peacemakers Alliance; Northern Ohio Trauma System (NOTS)

University Hospitals Cleveland Medical Center
EMS Institute, Stop the Bleed Training
CHNA Priority: **Homicides / Violence / Safety**
Strategy 9: Provide *Stop the Bleed* training and supplies to schools in Cuyahoga County. Stop the Bleed is a national awareness campaign intended to cultivate grassroots efforts that encourage bystanders to become trained, equipped, and empowered to help in a bleeding emergency before professional help arrives.
Goals: • To provide awareness and education on bleeding control in schools in the event of traumatic injuries in school districts within Cuyahoga County.
Objective: • Meet with school system leadership to implement Stop the Bleed curriculum by December 31, 2019.
Anticipated Outcomes: • Train 20% percent of the schools in Cuyahoga County in 2019 • Schedule trainings for an additional 30% of schools for 2020 • 20% of students and classified/non-classified staff trained • Bleeding control kits distributed to all participating schools **Indicators used to measure impact of outcomes:** • N/A
Collaboration and Partnerships: Fire departments; mayors; safety directors; school districts

University Hospitals Cleveland Medical Center
Step Up to UH
CHNA Priority: **Poverty**
Strategy 10: • Employment and retention - work with community partners to recruit and provide soft skill training to community residents for employment in Environmental Services and Nutrition Services at UH Cleveland Medical Center
Goals: • Increase employment options among community members residing in neighborhoods surrounding UH Cleveland Medical Center. • Decrease unemployment in an under-resourced community. • Increase financial stability and access to healthcare for under-resourced populations.
Objectives: • Offer 4 cohorts of soft skills training • Complete soft skills training for 80 people annually • Hire 35-40 program participants • 78% retention rate for employees recruited via Step Up to UH
Anticipated Outcomes: • Increased financial stability for individuals living in the Greater University Circle (GUC) footprint • Improved economic inclusion and wealth building as part of the GUC anchor strategy **Indicators used to measure impact of outcomes:** • Number of program participants who are hired by UH *(Source for Data: UH)* • Number of program participants who are hired and who are still employed after one year *(Source for Data: UH)*
Collaboration and Partnerships: Neighborhood Connections; Towards Employment

University Hospitals Cleveland Medical Center
Community Impact, Equity, Diversity and Inclusion (CEDI), UH Health Scholars Program
CHNA Priority: **Poverty**
Strategy 11: • Facilitate a pipeline program for minoritized* secondary school students
Goal: • Create a pipeline for local minoritized secondary students to understand and pursue careers in medicine
Objectives: • Work with 30 students throughout the year (school year and summer) to build and develop social/emotional learning, executive functioning skills, and an academic profile that will get them into and through the necessary post-secondary education/training to become physicians.
Anticipated Outcomes: Students will have the necessary social/emotional skills, executive functioning skills, and an academic profile to be successful physicians **Indicators used to measure impact of outcomes:** • Students' scores on Health Scholars assessments • Number of students who complete all necessary high school classes needed to enter a pre-professional/pre-med college program • School grades • Standardized test scores • Proportion of program graduates who are accepted into an accredited pre-professional four-year degree program which prepares students for medical school *(Source for Data: UH)*
Collaboration and Partnerships: Shaker Heights High School; Cleveland School of Science and Medicine; Case Western Reserve University

*The definition of minoritize is "to make a minority" (minority+ize). It acknowledges the process and product of being a person who is called a "minority." Minoritized individuals include:

- Groups of people that are different and as a result of social constructs have less power or representation compared to other members or groups in society
- People forced into a group that is mistreated or faces prejudices such as sexism, ableism, racism, xenophobia, homophobia, islamophobia, etc.
- People that are discriminated against because of situations outside of personal control

University Hospitals Cleveland Medical Center
Otis Moss Center, Food for Life Market
CHNA Priority: **Poverty***
Strategy 12: • Providing food for UH patients when they experience food insecurity
Goals: • Reduce food insecurity of UH patients • Reduce hemoglobin A1C levels of food insecure UH patients • Reduce blood pressure of food insecure UH patients
Objectives: • Provide 35 pounds/person of shelf food, fresh produce, and nutrition coaching and counseling for a subset of UH patients
Anticipated Outcomes: • Ensure subset of UH patients have basic needs met • Reduction in the amount of stress experienced by 1,200 UH patients • Reduction in the blood pressure and A1C levels of food insecure UH patients **Indicators used to measure impact of outcomes:** • Improved self-report of food insecurity among program participants *(Source for Data: UH)* • Decreased hospitalization rates among program participants *(Source for Data: UH)*
Collaboration and Partnerships: Sodexo; Olivet Institutional Baptist Church

*This strategy also addresses chronic disease management and prevention

University Hospitals
Parma Medical Center

STRATEGIES

UH Parma Medical Center

For more than 50 years, University Hospitals Parma Medical Center has been serving the health care needs of the residents of Parma, Parma Heights, Brooklyn, Brooklyn Heights, Seven Hills, North Royalton and surrounding communities.

This 332-bed full-service hospital employs more than 1,300 Northeast Ohio residents, and has more than 700 physicians trained in more than 30 specialties on its medical staff. This includes experts in emergency medicine, heart and vascular disease, cancer, bariatric surgery, pain management and acute rehabilitation. UH Parma Medical Center has also received national recognition for its orthopedics program and cardiovascular outcomes.

Radiology and diagnostic imaging, physical therapy and laboratory services are available at multiple locations, while home health care, hospice, screenings and educational programs round out the full spectrum of services. UH Parma Medical Center is a preferred provider for all major managed care plans, delivering exceptional care, close to home.

University Hospitals Parma Medical Center

CHNA Priority: **Chronic Disease Management and Prevention**

Strategy 1:
The overall strategy is to continue to increase UH Parma Medical Center's outreach efforts in order to ensure all community members, and especially those historically under-resourced, have access to health information, education, health screenings and wellness-building services.

- Conduct community-based events which offer screenings, publications and handouts
- Provide community-based programming to improve behavioral lifestyle choices
- Offer structured exercise programs at the Health Education Center
- Mail educational materials to households
- Provide medical and clinical professionals to speak at events
- Provide CPR/AED training in the community

Goal:

- Increase patient and community member awareness of support programs, screenings and understanding of chronic diseases. Provide navigation services where applicable to access care.

Objectives:

- Screen at least 500 individuals who are managing a chronic disease
- Promote healthy lifestyle choices to at least 500 individuals
- Participate in at least 200 outreach screening events

Anticipated Outcome:

- Improve health literacy and health outcomes among current chronic disease patients and community members through programs and education

Indicators used to measure outcome:

- Proportion of adults who have been told by a health professional that they have diabetes or prediabetes, cardiac or pulmonary disease in the past year *(Source for Data: BRFSS, baseline 2019)*
- Proportion of adults who engage in chronic disease prevention or control prevention behaviors (exercise, controlled diet, controlled weight, regular visits to health care professional) *(Source for Data: BRFSS, baseline 2019)*

Collaboration and Partnerships:
Senior centers in UH Parma service areas; community health fairs; Alzheimer's Association, CBS Connects (Parma City Schools), Parkinson's Foundation, Partnership for a Healthy North Royalton, North Royalton School District, The Arthritis Foundation, Parma City School District; Parma Area Family Collaborative; Padua High School; St. Albert The Great School; Brecksville/Broadview Heights School District; North Royalton YMCA; YMCA of Greater Cleveland; American Heart Association, Parma Libraries, West Creek Conservancy; cities of Parma, North Royalton, Parma Heights, Seven Hills, Brooklyn, Brooklyn Heights and Broadview Heights

University Hospitals Parma Medical Center

CHNA Priority: **Poverty***

Strategy 2:
The overall strategy is to increase access to healthy foods for the most vulnerable community members.

- Provide healthy, affordable food through Meals on Wheels program to residents in the cities of: Brooklyn, Seven Hills and Parma
- Provide Kids Summer Lunch Program with Sodexo (a food management company)
- Integrate UH Parma events with The Hunger Network "Stay Well" program in targeted areas
- Provide discounted/no cost healthcare for eligible patients/provide subsidized healthcare
- Provide free screenings

Goal:

- Improve the quality of life for those in the UH Parma service areas demonstrating poverty and/or food insecurity

Objective:

- Provide health information and food/meal assistance to medically underserved areas and/or persons with food insecurities

Anticipated Outcomes:

- Provide at least 225 meals through Kids Summer Lunch Program
- Provide at least 2,000 meals through Meals On Wheels program

Indicators used to measure impact of outcomes:

- Number of community members who report food insecurity issues *(Source for Data: BRFSS)*
- Decreased child asthma hospitalizations *(Source for Data: UH)*

Collaboration and Partnerships:
The Hunger Network of Greater Cleveland; Parma Area Collaborative; local food pantries; Sodexo, cities of Seven Hills, Parma and Brooklyn, Rainbow Babies and Children's Hospital

*This strategy also addresses chronic disease management and prevention

University Hospitals
Rainbow Babies & Children's

STRATEGIES

UH Rainbow Babies & Children's Hospital (RBC)

UH Rainbow Babies & Children's Hospital is a 244-bed, full-service children's hospital and academic medical center. A trusted leader in pediatric health care for more than 125 years, UH RBC consistently ranks among the top children's hospitals in the nation. As the region's premier resource for pediatric referrals, UH RBC's dedicated team of more than 1,300 pediatric specialists uses the most advanced treatments and latest innovations to deliver the complete range of pediatric specialty services for 700,000 patient encounters, annually.

University Hospitals Rainbow Babies & Children's Hospital

CHNA Priority: **Chronic Disease Management and Prevention**

Strategy 1:

- Continue to bring dental care directly to children who need it most through UH Rainbow Babies & Children's Hospital's Ronald McDonald Care Mobile, a 42-foot-long, three operatory mobile dental clinic.
    - The Care Mobile travels throughout Northeast Ohio to provide much needed dental care to children ages 3 to 12 in underserved populations, many of whom get their first glimpse of a dentist's chair through this service.
    - Tooth decay is the most common chronic childhood disease in America. One in every 5 children aged 5 to 11 have at least one untreated decayed tooth. It's a problem that overwhelmingly effects children from low income families, who are less likely to receive regular dental care. More than 51 million school hours are lost each year to dental-related illness in the U.S.

Goals:

- To continue to reach underserved children throughout a 20 county area to provide routine dental screenings and cleanings.
- In addition to preventive care, treatment options include filling cavities, extractions, pulp therapy and placing crowns.
- In addition, the pediatric mobile dental unit endeavors to provide treatment to at least 93% of children served on the Care Mobile instead of referring out—this ensures that children will get the restorative care they need through prompt follow-up appointments in their community on the Care Mobile.

Objectives:

- Continue to reach underserved children throughout a 20 county area to provide preventive care, sealants, fluoride treatment, and treatment of dental caries
- Increase the number of schools and geographic diversity, Head Starts, and public health agencies reached each year
- Increase the number of low-income children reached each year who do not have a regular source of preventive dental care
- Increase the number of patients whose treatment takes place right on the Care Mobile in their community

Anticipated Outcomes:

- At least 2,400 pediatric patients seen in a minimum of 8 counties
- 93% or more children receive their treatment on the Care Mobile
- Significant proportion of children receive sealants and/or fluoride varnish treatments

Indicators used to measure impact of outcomes:

- Decreased number of children with Emergency Department visits due to dental issues *(Source for Data: UH)*

Collaboration and Partnerships:

Ronald McDonald House Charities of Northeastern Ohio; Case Western Reserve University School of Dental Medicine; school districts; DDC Clinic; public health departments; and residential treatment facilities throughout NEO.

University Hospitals Rainbow Babies & Children's Hospital

CHNA Priority: **Chronic Disease Management and Prevention**

Strategy 2:

- Improved chronic disease management and prevention.

Goals:

- Deliver interactive nutrition education and family-centered cooking instruction.

Objectives:

- Offer at least 45 hours of nutrition outreach programs (classes 2x/month) by December 31, 2019 held at UH Rainbow Center for Women and Children and Dave's community teaching kitchen.

Anticipated Outcomes:

- Improved health and nutrition literacy among vulnerable patient populations such as cancer patients and patients with diet-related chronic diseases such as cardiovascular disease, diabetes, and obesity.

Indicators used to measure impact of outcomes:

- Percent of patients who report consuming 5 or more servings/day fruits and vegetables *(Source for Data: UH)*
- Percent of patients with self-reported improved self-efficacy on post-surveys related to healthy meal preparation for self and family. *(Source for Data: UH)*
- Decreased proportion of children in targeted areas (zip codes) with a high BMI and/or high blood pressure* *(Source for Data: Better Health Partnership)*

Collaboration and Partnerships:

Dave's Markets; Local Matters; MidTown Cleveland Inc.; Sodexo; and the Greater Cleveland Food Bank.

University Hospitals Rainbow Babies & Children's Hospital
CHNA Priority: **Chronic Disease Management and Prevention**
Strategy 3: • Food insecurity resource coordination.
Goal: • Offer on-site produce distribution program.
Objective: • Serve an average of 50 patients per month with healthy harvest produce distribution program by July 1, 2019.
Anticipated Outcomes: • Improved healthy food access and nutrition literacy among vulnerable patient populations such as cancer patients, prenatal care patients, and patients with diet-related chronic diseases such as cardiovascular disease, diabetes, and obesity. **Indicator used to measure outcomes:** • Percent of patients who report consuming 5 or more servings/day fruits and vegetables. *(Source for Data: UH)*
Collaboration and Partnerships: Green City Growers; Sodexo; Greater Cleveland Food Bank; Dave's Markets; and MidTown Cleveland Inc.

University Hospitals Rainbow Babies & Children's Hospital

CHNA Priority: **Infant Mortality**

Strategy 4:

- Offer Centering Pregnancy program

Goals:

- To improve birth outcomes through the innovative Centering Pregnancy program that provides education, outreach, and coordination of healthcare and social services for pregnant women.

  The Centering Pregnancy model combines health assessment, interactive learning and community building to help support positive health behaviors and drive better health outcomes. It brings patients out of the exam room and into a group setting with other pregnant moms which also helps build their community of support.

Objectives:

- Increase in number of women participating
- Continue to expand the Centering program by including partnerships with home visiting organizations and enhancing the curriculum to fit patient needs
- Reduce maternal stress and depression using Centering program's group dynamic
- Educate participants about breastfeeding, infant mortality, and safe sleep
- Provide essential services during pregnancy for improved birth outcomes

Anticipated Outcomes:

- Decrease pre-term deliveries by one percentage point
- 5% or fewer low-birth weight babies
- Increase appointment compliance to 75%
- Increase postpartum attendance visits to 75%
- Increase breastfeeding rates at discharge to (80%) and at 6-weeeks to (65%)
- Serve 500 mothers

Indicators used to measure impact of outcomes:

- Decreased infant mortality rate
- Decreased rate of preterm births (<37 weeks gestation)
- Decreased rate of very premature births (< 32 weeks)
- Decreased proportion of low weight births

(Source for Data: Vital Statistics; Cuyahoga County Board of Health; First Year Cleveland)

Collaboration and Partnerships:
Centering Healthcare Institute; The Centers for Families and Children

University Hospitals Rainbow Babies & Children's Hospital

CHNA Priority: **Infant Mortality**

Strategy 5:

- Centering Pregnancy approach to prenatal care

Goal:

- Strengthen nutrition education delivered during Centering Pregnancy programs

Objective:

- Incorporate food-based learning activity or recipe demonstration in weeks 1 and 2 of curriculum.

Anticipated Outcomes:

- Reduce incidence of gestational diabetes among prenatal care patients
- Reduce maternal postpartum readmissions related to inadequate diet

Indicator used to measure outcomes:

- Reduced low birth weight deliveries *(Source for Data: UH; Cuyahoga County Board of Health; First Year Cleveland)*
- Reduced very preterm births (<32 weeks gestation) *(Source for Data: Vital Statistics; Cuyahoga County Board of Health)*
- Reduced preterm births (<37 weeks) *(Source for Data: Vital Statistics; Cuyahoga County Board of Health)*

Collaboration and Partnerships:

Sodexo; Birthing Beautiful Communities; Greater Cleveland Food Bank

University Hospitals
St. John Medical Center
A CATHOLIC HOSPITAL

STRATEGIES

UH St. John Medical Center

Since opening in 1981, University Hospitals St. John Medical Center has remained committed to providing the residents of western Cuyahoga and eastern Lorain counties with excellent health care in a faith-based Catholic hospital setting. This non-profit, acute care hospital in Westlake, Ohio, is a 204-bed full-service facility, offering comprehensive medical and surgical care for children and adults.

Services include a 24-hour emergency room, urology care, orthopedics, neurology and a family birth center. It also offers onsite diagnostic imaging and lab services, and a range of other services for its patients, families and visitors.

UH St. John Medical Center is one of the largest employers in the City of Westlake with more than 1,200 employees, including more than 500 medical staff. UH St. John Medical Center is a teaching hospital and maintains an affiliation with the Ohio University Heritage College of Osteopathic Medicine. Also, the medical center is affiliated with Westshore Primary Care, Inc., a consortium of more than 50 physicians who range in specialties from family practice to obstetrics.

University Hospitals St. John Medical Center
CHNA Priority: **Chronic Disease Management and Prevention**
Strategy 1: • Community education and awareness, exercise promotion and preventative health screenings
Goals: • Support individual self-management of chronic diseases • Promote healthy lifestyle behaviors • Increase health behaviors that contribute to the prevention of chronic diseases including exercise, weight management, healthy nutrition, and stress relief. • Increase awareness and education of chronic disease self-management skills through health talks, classes, disease-specific literature and other resources
Objectives: • Screen at least 500 individuals who are managing a chronic disease • Promote healthy lifestyle choices to 500 individuals • Increase awareness and education of chronic disease self-management skills to 1,500 individuals
Anticipated Outcomes: • Improved health literacy, skills and motivation • Positive changes in support of healthy behavior and reduction in health risks • Increased ability to recognize changes in a chronic disease based on screenings and education **Indicators used to measure impact of outcomes:** • Proportion of individuals self-reporting positive health status *(Source for Data: BRFSS)*
Collaboration and Partnerships: • American Diabetes Association, American Heart Association, Colon Cancer Alliance, Crohns and Colitis Foundation, Cuyahoga County Board of Health, Far West, Porter and Lakewood Libraries, The Gathering Place, United Way, Veterans Administration, Westlake Community Services, Westlake Food Pantry, Westshore YMCA • Local senior centers, Great Northern Mall; Bay Village Schools, North Olmsted and Westlake Schools • Schools, Area Extended care Facilities, Westside Health Organization, Fire Stations, Westlake Recreation Center, American Cancer Society, Rite Aid, Fairhill Partners, City of Westlake

University Hospitals St. John Medical Center
CHNA Priority: **Opioids / Substance Use Disorders / Mental and Behavioral Health**
Strategy 2: • Ongoing participation and contribution to the county-wide Opiate Abuse Advisory Committee
Goals: • To increase awareness and provide education on heroin and opiate abuse prevention
Objectives: • To provide education to at least 200 individuals on the scope and course of opiate abuse in our community • To increase awareness and use of non-pharmacological pain management as evidence-based and a safe alternative to curb opiate abuse for at least 150 individuals
Anticipated Outcome: • Increased knowledge of participants at educational events • Increased awareness regarding options for pain management and complimentary therapies **Indicators used to measure outcome:** • Pre-post results from events *(Source for Data: UH)* • Number of opioid overdoses within St. John's primary market area *(Source for Data: ODH Public Health Data Warehouse)* • Number of opioid overdose deaths within St. John's primary market area *(Source for Data: ODH Public Health Data Warehouse)*
Collaboration and Partnerships: • Cuyahoga County Opiate Task Force; West Shore Enforcement Bureau; Lorain County Alcohol, Drug and Addiction Services (LCADA); St. John Medical Center Pain Management Clinic; UH Psychiatrist; Project DAWN, Ohio Pharmacy Board, Catholic Charities Matt Talbot for Women, The Center for Health Affairs, Laurelwood, SVCH Rosary Hall, The City of Westlake Community Services, The City of Westlake Fire and Rescue, The City of Westlake Police, UH Case Medical Center

Other UH Community Health Initiatives

University Hospitals has contributed over $2.63 billion in the past decade toward critical needs in our community. From its participation in long term regional efforts such as the Greater University Circle Initiative (GUCI) and Say Yes to Education; to non-profit board participation; free and discounted care to those unable to afford healthcare; subsidized healthcare to beneficiaries of Medicaid and other government programs; numerous sponsorships to non-profit organizations that help address priority-needs identified in its Community Health Needs Assessments (CHNAs); and training for the next generation of medical professionals. These ongoing efforts occur in addition to the strategies developed in response to each new CHNA -- a few of them are listed below:

University Hospitals Collaboration with Greater University Circle Initiative

Economic prosperity and economic insecurity are important social determinants of health status. University Hospitals helps lift our regional and state economies with thousands of jobs and a focused effort on local purchasing. It has been a committed partner of the Greater University Circle Initiative (GUCI) since its inception. GUCI is an anchor strategy of three major institutions in the heart of Cleveland, which was spearheaded by The Cleveland Foundation and operational for the past 13 years. Its goals are Buy Local, Live Local, Hire Local and Connect:

Buy Local - UH invests in buying local products. It has spent over $4.8 million on services in a conscious effort to invest in local companies. It continues to support Evergreen Cooperatives, which includes Green City Growers, Evergreen Cooperative Laundry and Evergreen Energy Solutions.

Live Local – UH encourages employees to become residents through home purchasing, rental assistance and exterior upgrades and repairs through the Greater Circle Living program, providing over $900,000 since 2014. As a result, 117 employees have taken advantage of this strategic initiative to attract and retain residents in the city of Cleveland.

Hire Local – Since 2013, more than 399 local residents have been hired at UH through the Step Up to UH program and New Bridge Cleveland Center for Arts and Technology through GUCI.

Additionally, UH was actively involved with other Greater University Circle partners to implement lead-safe homes and infant mortality strategies in two strategic GUC neighborhoods. It continues to support regional efforts to address these critical issues.

UH Clinic and Institutes

University Hospitals Cleveland Medical Center has a number of clinics and institutes specifically developed to expand the scope of clinical and/or wrap-around services for its patients. These services go above and beyond the standard level of care to address target populations experiencing adverse conditions. These programs and services complement and enhance UH's more direct community health strategies and align with Cuyahoga county's five priority-need areas. Most of these clinics are subsidized by the health system to ensure that patients receive necessary care.

Douglas Moore Clinic

The Douglas Moore Clinic has been designated as being in a primary care Health Professional Shortage Area. The Heart Failure Program, started in 2013, in the Cleveland Medical Center's Douglas Moore Clinic, has become an integral part of the health care services provided to under-resourced populations in Cleveland. The partnership

between the Cardiology/Heart Failure team and Internal Medicine Practice team at Douglas Moore Clinic has been successful in reducing heart failure readmissions by providing disease, drug, and dietary education, thereby improving patient compliance. UH reduced hospital re-admissions by scheduling shorter interval follow-up office visits and frequent phone calls by nurses and health coaches to provide patient education, and to review complex medical regimens. This intensive program is now standard practice within the Douglas Moore Clinic and is responsible for improving health outcomes, quality of life and patient satisfaction for more than 1,200 patients to date.

The Douglas Moore Clinic is staffed by Internal Medicine residents and attending physicians. It aims to increase the proportion of physicians who integrate preventive primary care with chronic and primary care of cardiac patients.

Medical Access Clinic

The Medical Access Clinic is run in conjunction with the Department of Family Medicine and the Department of Emergency Medicine to treat non-emergent patients in a clinical setting after they have been triaged and medically screened to meet EMTALA (The Emergency Medical Treatment and Labor Act) regulations. The Medical Access Clinic is staffed by nurse practitioners and family medicine physicians and provides clinical care for patients and establishes links to primary care. The clinic sees an average of 8,000 patients per year and 97% of them have not returned to the Center for Emergency Medicine (CEM for non-emergent visits. They are also provided education on how to manage their medical conditions and access to care.

Pain Management Institute

The UH Pain Management Institute brings together providers throughout the UH system and across multiple disciplines including primary care, anesthesiology, surgery, emergency medicine, pediatrics, psychiatry, pain management and the UH Connor Integrative Health Network to optimize patient care. The UH approach not only spans multiple practice disciplines, but serves as an end-to-end model from provider prescribing education, to comprehensive inpatient and outpatient care, to referral services into the community. The mantra for the institute: maximize function and minimize risk for patients living with pain.

In 2018, numerous events were held system wide to educate providers on safe, responsible prescribing practices. To reinforce accountability and the importance of changing the prescribing culture, UH's Board and senior leaders engaged in a retreat where information was shared about the subject. UH also facilitates clinician education for community providers, sponsoring events such as the UH Connor Integrative Health Symposium and the Pediatric Pain and Palliative Care Week. Additionally, as a member of the Cuyahoga County Task Force, UH holds community outreach events, including safety fairs to educate the community on opioid awareness.

Additionally, UH joined with other area health systems and The Center for Health Affairs to create The Northeast Ohio Hospital Opioid Consortium in 2016 – a unique hospital system-based and physician-led collaborative. The inaugural chair of the consortium is Dr. Randy Jernejcic, Vice President of Clinical Integration at UH. The consortium's goal is to share and implement evidence-based practices, promote policy changes and increase prevention efforts related to the opioid epidemic.

UH Otis Moss, Jr. and Olivet Community Health & Wellness Center

For over 20 years, University Hospitals Otis Moss, Jr. Health Center has been serving the Greater Cleveland area and especially our neighbors in the Fairfax community. UH Otis Moss Center was established in close partnership with the Olivet Institutional Baptist Church in 1997. The center provides high-quality patient care in a spiritually supportive environment. This new model of care will allow walk-in access with convenient and extended hours. In 2017, UH and Olivet reaffirmed their commitment to the community by expanding and enhancing services beyond access to excellent primary care.

Most recently, the center became the home to an innovative program to help patients with chronic conditions obtain healthy foods more conveniently, the Food for Life Market. In addition to a patient home for Family and primary care, the center will offer specialty services which include brain health (a focus on Alzheimer's, dementia, and addictive medicine), urology and a comprehensive care for male health. Expanded community services will support workforce development, health care education and programs addressing the social determinants of health.

UH Rainbow Center for Women and Children

Expanding the concept of traditional hospital-based medical care to include addressing the overall health and wellness of the community, UH Rainbow Center for Women & Children provides an oasis of health care, education and support for families in the heart of Cleveland's vibrant and inclusive MidTown neighborhood. Along with necessary healthcare delivery for women and children, the 40,000-square-foot, three-story, urban center addresses health disparities and social determinants of health that affect wellness. The incorporation of sustainable design principles ensures a green, healthy building for patients and staff.

UH Rainbow Babies & Children's Hospital enlisted neighborhood residents; local organizations, representing education, housing and public health; faith-based organizations; and community development corporations to form the Community Advisory Board to determine what medical care and social programs are at the center. The center brings together, in one convenient location, OB/GYN, pediatric primary care and adolescent healthcare services, plus social services to make it easier for area residents to lead healthier lives. In addition, education and advocacy are at the core of the center's mission, and it is a primary site for training the next generation of pediatric and OB/GYN clinicians.

Programs and services:

- Integrated mental and behavioral health services
- Nutrition education and health food programs, including counseling provided by dieticians
- OneSight, a full-service vision clinic
- Dental screening and cleaning
- Medical-legal partnership
- WIC (Women, Infants and Children) office
- Pharmacy

The Cleveland Department of Public Health and the Cuyahoga County Board of Health

The Cleveland Department of Public Health and the Cuyahoga County Board of Health are not required to report strategies associated with the 2018 CHNA until 2020. Although this is a "bridge" year until the 2020-2022 joint Cuyahoga County IS is developed, the health departments and hospitals will implement one collective strategy which is described in a later section.

Both public health departments have significant programming that addresses the five priority health needs. Related to addressing poverty, the Cleveland Department of Public Health's Office of Minority Health aims to identify local health disparity needs with an emphasis on informing, educating, empowering at-risk communities and providing minority health data and technical assistance to local agencies that are working to improve the health status of minority populations. CDPH's deliberate and intentional efforts in addressing poverty are built into their programs, specifically around reducing rates of infant mortality, lead poisoning, maternal and sexual health, HIV and communicable diseases and providing outreach and education specific to the needs of the Cleveland community.

In addition, Cleveland Department of Public Health's Division of Air Quality and Division of Environment work to ensure safe environments for all residents, especially among those who are of lower income and/or at risk for higher health risks. For example, Cleveland Department of Public Health's Division of Air Quality monitors ambient air emissions from industrial sources.

To address the opioid epidemic, both health departments, in collaboration with the Alcohol, Drug Addiction and Mental Health Services Board of Cuyahoga County, MetroHealth, the Ohio Department of Health, Circle Health Services, the Substance Abuse and Mental Health Services Administration, Cleveland EMS, and the Hispanic Urban Minority Alcoholism Drug Abuse Outreach Project, raise awareness, provide education, and distribute naloxone kits to address opioid overdoses. Cuyahoga County Board of Health coordinates the Cuyahoga County Opiate Task Force which is comprised of the following stakeholder groups: drug treatment/recovery, education, health care, law enforcement, medicine, prevention specialists, mental health services, concerned citizens and public health.

To address other behavioral health needs, Cleveland Department of Public Health's Office of Mental Health and Substance Abuse provides an Alcohol and Other Drug treatment program called CenterPoint which is located in the J. Glen Smith Health Center in the Glenville neighborhood. Cuyahoga County Board of Health and Cleveland Department of Public Health collaborate with a syringe service program and efforts to safely dispose of unused prescription medications.

Public health involvement in infant mortality initiatives includes Cleveland Department of Public Health's MomsFirst Program, which has served expectant women and their families with home-visiting, education and supportive services since 1991. The goal of MomsFirst is to reduce the number of babies that die before they are one year old. The program provides case management and home visiting services to pregnant women and new moms until their baby reaches age two. Women who participate in the MomsFirst program receive health education on topics such as prenatal care, breastfeeding, family planning, and safe sleep. MomsFirst also assists with referrals to meet other needs such as health insurance, housing, food and education. Along with their involvement in the Ohio Equity Institute and being a founding member of First Year Cleveland, Cleveland Department of Public Health's clinics provide pregnancy testing and reproductive health services on a sliding scale fee to improve maternal health. The Cuyahoga County Board of Health is involved in a variety of initiatives aimed at addressing infant mortality including the Cleveland-Cuyahoga Equity Institute, First Year Cleveland, the

Prevent Premature Fatherhood program, the Child Fatality Review Initiative and newborn home visiting program serving Medicaid families.

A series of strategies addressing violence are being implemented throughout Cleveland including releasing violence reports, implementing Cleveland Peacemakers Alliance, a partnership for a Safer Cleveland, and MyCom - which focuses on youth development.

Chronic disease management and prevention programs that public health partners are involved in include early childhood obesity and breast and cervical cancer prevention, healthy food financing, and Safe Routes to School. A partnership between both local health departments and Case Western Reserve University's Prevention Research Center for Healthy Neighborhoods has produced a series of Neighborhood Briefs which combine multiple years of data on chronic disease topics, such as diabetes, obesity, hypertension awareness, asthma, cigarette and other tobacco product use.

Aligned Hospital and Public Health Strategy

While public health partners were not required to complete a 2019 Cuyahoga County Community Health Implementation Strategy, they have worked collaboratively with the 8 University Hospital facilities located in Cuyahoga County to develop one aligned strategy in this bridge year to address a shared health priority for this IS. This demonstrates the intent of public health partners and University Hospitals to collaborate not just in developing joint CHNAs, but also in addressing health needs through more effective community health planning.

To determine an aligned strategy that public health partners and hospitals will work on collaboratively as part of the 2019 Cuyahoga County Community Health Implementation Strategy, several meetings were held that engaged representatives from the 8 University Hospital facilities, the two public health departments (Cleveland Department of Public Health and the Cuyahoga County Board of Health), and community stakeholders.

During the first meeting, UH hospitals and public health partners reviewed how their current programs and initiatives address the five health priorities from the 2018 CHNA. The group then generated a list of 11 potential aligned strategies based on a review of evidence-based strategies as well as new ideas generated during the meeting.

During the second meeting, UH hospitals, public health partners and community stakeholders met to review the list of 11 potential aligned strategies. Community stakeholders provided valuable and candid feedback about the 11 potential strategies which informed decision-making by hospitals and public health. The list of 11 potential aligned strategies was narrowed down to a list of 5 potential strategies (Appendix 3) based on that meeting.

A follow-up survey was sent to hospital and public health participants to allow voting on the 5 potential aligned strategies, with weighting to ensure that public health stakeholders and hospitals each received 50% of the vote. Survey results indicated a very close tie between two potential strategies: 1) equity, diversity, inclusion and cultural humility training and 2) trust-building with community residents.

Based on survey results and a follow-up call with hospital and public health stakeholders, the aligned strategy for the 2019 IS will focus on combining the two strategies that received the most votes. As a result, hospitals and public health partners will engage in equity, diversity, inclusion and cultural humility grounding in an effort to increase trust with community stakeholders. The initial step will be to ensure that all stakeholders come to consensus and have a shared understanding about the meaning of equity, diversity, inclusion and cultural humility. The second phase of the strategy will be to determine how to apply the grounding concepts to current work being planned, efforts which will include collaboration among hospitals, public health, and community stakeholders.

This strategy will continue to be developed and refined throughout the year, however once consensus on key terms has been achieved among key stakeholders during the grounding session, events which are currently being planned (i.e. UH's Family Health and Safety Days, resident-led initiatives, public health department events) will be co-developed with input from community stakeholders, public health partners and hospitals to increase their impact and ability to reach diverse members of the community. This strategy will likely extend beyond the one-year timeframe that is the focus of the 2019 IS.

Cleveland Department of Public Health / Community Stakeholders / Cuyahoga County Board of Health / University Hospitals
CHNA Priority: **Chronic Disease Management and Prevention; Opioids / Substance Use Disorders / Mental and Behavioral Health**
Strategy 1: • Hospitals and public health partners participate in equity, diversity, inclusion and cultural humility grounding and co-develop events with community stakeholders to boost trust levels.
Goals: • Hospitals and public health partners come to consensus and have a shared understanding of key terms that relate to equity, diversity, inclusion and cultural humility • Increased levels of trust among community stakeholders, public health partners and hospitals
Objectives: • Equity, diversity, inclusion and cultural humility grounding among hospitals and public health partners • Co-developed events that engage hospitals, public health and community stakeholders
Anticipated Outcome: • Community stakeholders have a greater trust of healthcare providers (hospitals and public health); healthcare providers have improved understanding and empathy for community members • Hospitals and public health partners have a shared understanding of key terms such as equity, diversity, inclusion and cultural humility **Indicators used to measure outcome:** • Pre- and post- surveys that measure hospital and public health stakeholders' shared understanding of equity, diversity, inclusion and cultural humility grounding concepts • Number of community stakeholders who participate in planning and deployment of events • Number of community stakeholders who participate in events *(Source for Data: UH)*
Collaboration and Partnerships: Community stakeholders; Cleveland Department of Public Health; Cuyahoga County Board of Health; University Hospitals

Significant Health Needs Not Being Addressed by Hospitals

The original list of 13 top health issues identified areas in which Cuyahoga County residents as a whole fare poorly compared to peer counties and to national benchmark goals. The prioritization process winnowed the list of health priorities down to five health priorities that comprise the focus of this IS. During the prioritization process, several health needs were combined into one health need (i.e. cardiovascular disease and diabetes became chronic disease management and prevention) and then selected as a health priority while others were not selected as a focus for the 2019 Cuyahoga County Community Health Implementation Strategy. This section describes why the remaining list of significant health needs are not being directly addressed by hospital programs in this IS.

Identified Health Need	Reason Not Directly Addressed in Current Plan
High blood lead levels	High blood lead levels are being addressed in UH clinical settings when patients present with elevated blood lead levels, but this issue is not being addressed as part of this IS because it requires a long term regional approach that is currently being developed by a multi-sector partnership. Examples of how local public health departments are involved in addressing high blood levels are described below.
Childhood asthma	Childhood asthma is being addressed in UH clinical settings, but this issue is not being addressed as part of this IS based on the decision to target resources to infant mortality strategies due to alarming rates in Cuyahoga County.
Influenza	Influenza is being addressed in UH clinical settings and by the public health departments as part of their ongoing services and was therefore not selected as a 2019 priority. Information on how public health departments respond to this health need are described below.
Tobacco use / chronic obstructive pulmonary disease	COPD is being addressed in UH clinical settings, as well as tobacco cessation for high- risk patients, but these issues are not being specifically addressed as part of this IS because of the overall strategy to foster wellness and prevention pertaining to all types of chronic diseases and risky behaviors. Examples of how local public health departments are addressing this health need are described below.
Suicide prevention	This issue is not being specifically addressed as part of this IS based on the decision to target resources to the current opioid epidemic.

Both public health departments continue to administer ongoing programs and services that address several identified health needs, including implementing comprehensive lead poisoning prevention programs that screen children for elevated blood lead levels, conducting risk assessments and state code enforcement in units where children are found to have elevated blood lead levels and referring families to grant and loan programs that provide funding to remediate lead hazards in the home. Funding sources from the US Department of Housing and Urban Development (HUD) may allow for the elimination of asthma triggers in homes where lead hazards exist when families qualify based on income levels.

City and county health departments also provide seasonal influenza vaccinations at their respective clinics, and track and report surveillance data on factors such as flu-like illness, over-the-counter sales of cold remedies and school absenteeism. They monitor the onset and course of seasonal influenza activity in the community and actively encourage residents and those at risk to get vaccinated annually.

Local health departments enforce the complaint driven statewide comprehensive Smokefree Ohio Law, which prohibits smoking in all public locations such as bars, restaurants, bowling alleys, and places of business. The Cleveland Department of Public Health, with its partners, crafted legislation that raised the age to purchase tobacco and tobacco products to 21, an initiative called Tobacco 21. The intent behind Tobacco 21, passed in 2015, is to restrict sales to minors in order to reduce future tobacco use, their health problems and those associated with second hand smoke including infant mortality and chronic diseases. Several other communities in Cuyahoga County, including the cities of Euclid and Cleveland Heights, have also passed Tobacco 21 legislation with additional communities in process.

The Cuyahoga County Suicide Prevention Coalition, coordinated by the Cuyahoga County Alcohol, Drug Addiction and Mental Health Services Board, is composed of organizations, community members and survivors dedicated to instilling hope, raising awareness, providing education and promoting resources in an effort to reduce the incidence of suicide and suicidal behavior in Cuyahoga County. Membership spans a broad range of community partners including mental health and addiction treatment and recovery agencies, social service, family advocates as well as representatives from the education, healthcare and faith-based community.

Community Collaborators

This IS was commissioned by University Hospitals. The UH Implementation planning Team included:

Brian Adams, University Hospitals Regional Hospitals
Elyse Bierut, University Hospitals
Pam Brys, University Hospitals Ahuja Medical Center
Vetella Camper, University Hospitals Regional Hospitals
Chesley Cheatham, University Hospitals Seidman Cancer Center
Paul Forthofer, University Hospitals St. John Medical Center
Mary Kiczek, University Hospitals St. John Medical Center
Margaret Larkins Pettigrew, University Hospitals Cleveland Medical Center
Sharon Nichols, University Hospitals Parma Medical Center
Danielle Price, University Hospitals
Lori Robinson, University Hospitals Regional Hospitals
Phillip Rowland-Seymour, University Hospitals
Adrianne Shadd, University Hospitals
Colletta Somrack, University Hospitals Ahuja Medical Center
Robyn Strosaker, University Hospitals Cleveland Medical Center
Mary Beth Talerico, University Hospitals Parma Medical Center
Onyinyechi Ukwuoma, University Hospitals Rainbow Babies & Children's Hospital
Kathryn Wesolowski, University Hospitals Rainbow Babies & Children's Hospital

The following public health partners informed the creation of an aligned strategy:

Dr. Assim Alabdulkader, Case Western Reserve University School of Medicine
Terry Allan, Cuyahoga County Board of Health
Dr. Adeola Fakolade, Case Western Reserve University
Merle Gordon, Cleveland Department of Public Health
Dr. Heidi Gullett, Case Western Reserve School of Medicine / HIP-Cuyahoga
Martha Halko, Cuyahoga County Board of Health
Chris Kippes, Cuyahoga County Board of Health
Adam Nation, Cleveland Department of Public Health

The following community stakeholders participated in a facilitated discussion that helped narrow down the original list of 11 potential aligned strategies to a list of 5 potential aligned strategies:

Erika Brown, Community Resident
Marilyn Burns, Community Resident
Delores Collins, A Vision of Change
Sara Continenza, Food Strong
Reverend Earnest Fields, Calvary Hill Church of God in Christ
Gwendolyn Garth, Kings & Queens of Art
Kaela Geschke, Neighborhood Connections
Cheryl Johnson, Community Resident
Judy Klobusnik, UH-PFPC
Frank Matranga, UH-PFPC
Jackie Morris, Neighborhood Connections / Community Resident
Alexander Robertson, Recess Cleveland
Barbara Wilcher, Neighbor-to-Neighbor Facilitator / Community Resident

Qualifications of Consulting Companies

The process to develop this IS was facilitated and written by Pat Cirillo, President, Cypress Research Group, Kirstin Craciun, Director of Community Outreach, The Center for Health Affairs and Candice Kortyka, Member Services Project Manager, The Center for Health Affairs.

The Center for Health Affairs, Cleveland, Ohio
The Center for Health Affairs is the leading advocate for Northeast Ohio hospitals. With a rich history as the Northeast Ohio hospital association, dating back to 1916, The Center serves as the collective voice of 36 hospitals spanning nine counties.

The Center recognizes the importance of analyzing the top health needs in each community while ensuring hospitals are compliant with IRS regulations governing nonprofit hospitals. Since 2010, The Center has helped hospitals fulfill the CHNA requirements contained within the Affordable Care Act. More recently, The Center has helped hospitals coordinate their community health planning efforts with those of public health departments to ensure alignment with state population health guidance. Beyond helping hospitals with the completion of timely CHNA reports, The Center spearheads the Northeast Ohio CHNA Roundtable, which brings member hospitals and other essential stakeholders together to spur opportunities for shared learning and collaboration in the region.

The Center's contribution to the 2019 Cuyahoga County Community Health Implementation Strategy - which included meeting facilitation, writing report narrative and project management - was led by The Center's community outreach director, supported by the Member Services project manager and overseen by The Center's senior vice president of member services. The Center engaged Cypress Research Group to provide expertise in statistical methods and evaluation of hospital program impact.

More information about The Center for Health Affairs and its involvement in CHNAs can be found at www.chanet.org.

Cypress Research Group, Cleveland, Ohio
Founded in 1997, Cypress Research Group focuses on quantitative analysis of primary and secondary market and industry data. Industry specialties include health care, hi-tech and higher education. Since 2002, Cypress Research Group has partnered with The Center for Health Affairs to conduct a range of studies including building forecast models for nurses and most recently to analyze data for community health assessments.

The 2019 Cuyahoga County Community Health Implementation Strategy was directed by the company's president and supported by the work of associates and research analysts. The company's president, as well as all associates and research analysts, hold graduate degrees in relevant fields.

Contact

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Appendices

Appendix 1

State Health Improvement Plan (SHIP)
The Hospitals closely considered the 2017-2019 State Health Improvement Plan (SHIP) for Ohio when identifying strategies. The SHIP serves as a strategic menu of priorities, objectives, and evidence-based strategies to be implemented by state agencies, local health departments, hospitals and other community partners and sectors beyond health, including education, housing, employers, and regional planning.

The SHIP includes a strategic set of measurable outcomes that the state will monitor on an annual basis. Given that the overall goal of the SHIP is to improve health and wellbeing, the state will track the following health indicators in particular, to measure impact:

- **Self-reported health** status (reduce the percent of Ohio adults who report fair or poor health)
- **Premature death** (reduce the rate of deaths before age 75)

In addition to tracking progress on overall health outcomes, the SHIP will focus on three priority topics:

1. **Mental health and addiction** (includes emotional wellbeing, mental illness conditions and substance abuse disorders)
2. **Chronic Disease** (includes conditions such as heart disease, diabetes and asthma and related clinical risk factors-obesity, hypertension and high cholesterol, as well as behaviors closely associated with these conditions and risk factors- nutrition, physical activity and tobacco use)
3. **Maternal and Infant Health** (includes infant and maternal mortality, birth outcomes and related risk and protective factors impacting preconception, pregnancy and infancy, including family and community contexts)

The SHIP also takes a comprehensive approach to improving Ohio's greatest health priorities by identifying cross-cutting factors that impact multiple outcomes: health equity, social determinants of health, public health system, prevention and health behaviors, and healthcare system and access.

By October 2020, ISs are required to select at least 2 priority topics, 1 priority outcome indicator, 1 cross cutting strategy and 1 cross-cutting outcome indicator to align with the 2020-2022 SHIP. University Hospitals has chosen to demonstrate alignment with the current version of the SHIP in advance of the requirement.

State health improvement plan (SHIP) overview

Overall health outcomes

- ⬆ Health status
- ⬇ Premature death

3 priority topics

Mental health and addiction	Chronic disease	Maternal and infant health

10 priority outcomes

Mental health and addiction	Chronic disease	Maternal and infant health
⬇ Depression	⬇ Heart disease	⬇ Preterm births
⬇ Suicide	⬇ Diabetes	⬇ Low birth weight
⬇ Drug dependency/ abuse	⬇ Child asthma	⬇ Infant mortality
⬇ Drug overdose deaths		

Equity: Priority populations for each outcome

4 cross-cutting factors

- Social determinants of health
- Public health system, prevention and health behaviors
- Healthcare system and access
- Equity

Overview of guidance for local alignment with the SHIP

See ***ODH guidance for aligning state and local efforts*** for details

Select at least 2 priority topics (based on best alignment with findings of CHA/CHNA)

Select at least 1 priority outcome indicator within each selected priority topic (see master list of SHIP indicators)

Identify priority populations for each priority outcome indicator (based on findings from CHA/CHNA) and develop targets to reduce or eliminate disparities

- **Select at least 1 cross-cutting strategy** relevant to each selected priority outcome (see community strategy and indicator toolkits) **AND**
- **Select at least 1 cross-cutting outcome indicator** relevant to each selected strategy (see community strategy and indicator toolkits)

For a stronger plan (optional), select 1 strategy and 1 indicator for each of the 4 cross-cutting factors.

- Prioritize selection of strategies likely to decrease disparities (see community strategy and indicator toolkits)
- Ensure that delivery of selected strategies is designed to reach priority populations and high-need geographic areas

Appendix 2

Original List of 13 Significant Health Issues

These 13 significant health issues were originally identified through a careful analysis of the qualitative and quantitative data provided in the 2018 Cuyahoga County Community Health Assessment. From this list of 13 health issues, a two-step process was used to arrive at the final list of five prioritized health needs that were the focus of the 2019 Cuyahoga County Community Health Implementation Strategy.

Quality of Life

- Poverty
- Food insecurity

Chronic Disease

- Lead poisoning
- Cardiovascular disease
- Childhood asthma
- Diabetes

Behavioral Health

- Flu vaccination rates
- Tobacco use/COPD
- Lack of physical activity

Mental Health and Addiction

- Suicide/mental health
- Homicide/violence/safety
- Opioids/substance use disorders

Maternal/Child Health

- Infant mortality

Appendix 3

5 Aligned Strategies Voted On

12,000 STRONG
Volunteers would identify activities/services among the partners which are designed to improve wellbeing and behavior modification (i.e. mindfulness, exercise, massage/reiki, nutrition, Adverse Childhood Experience screening and services, etc.). Included in that catalogue would be the type, size, and populations served of all programs. Armed with that information, a "campaign" would be launched where community members (goal: 12,000) join in a year-long challenge to improve their health status in the *STRONG* categories. Improvement would come via small, incremental change in lifestyle and choices. The challenge would require some type of enabling technology (and "app") that would allow participants to log progress and see the aggregate result of everyone's effort at the end of the year.

Early Childhood
A small team of experts from the hospitals and public health departments review the current research literature and other published sources to identify best practices in home visitation programs where the desired impact is reduced child maltreatment.

- Capturing SDOH information at home visits and/or universal SDOH screening at UH
- Connect to the Accountable Health Communities work that United Way is spearheading
- Once best practices are identified, the local home visitation programs are reviewed (via contact with program leadership) to determine the practices used locally and identify where programs could be improved via integration of identified best practices.

Trauma
Community effort related to how to interface with clients that have experienced trauma. This includes adverse childhood experiences (ACEs) and trauma-informed care.

Trust-building with community residents
Develop a plan to increase the level of trust between community residents and hospitals and public health.

Equity, Diversity, Inclusion and Cultural Humility training

- Ongoing equity, diversity, inclusion, cultural humility training (staff, leadership, out in the community) taking action with evidence-based tools. Broadly speaking (i.e. rape survivor and gender of her practitioner). Includes trauma-informed care & ACEs work implementation.
    - There are several strong equity/inclusion awareness building and training classes already developed. This action plan would focus on ensuring all health care workers have received the training.

We welcome comments and feedback on ways to improve this document in future editions.

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Cuyahoga County Board of Health
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HiP Cuyahoga
Health Improvement Partnership

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