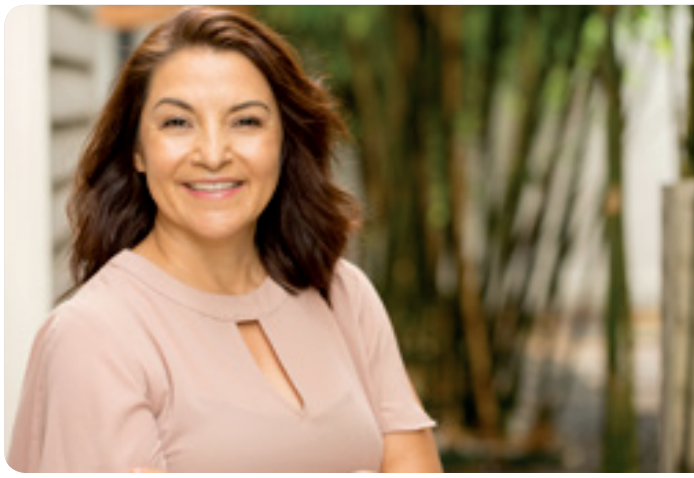
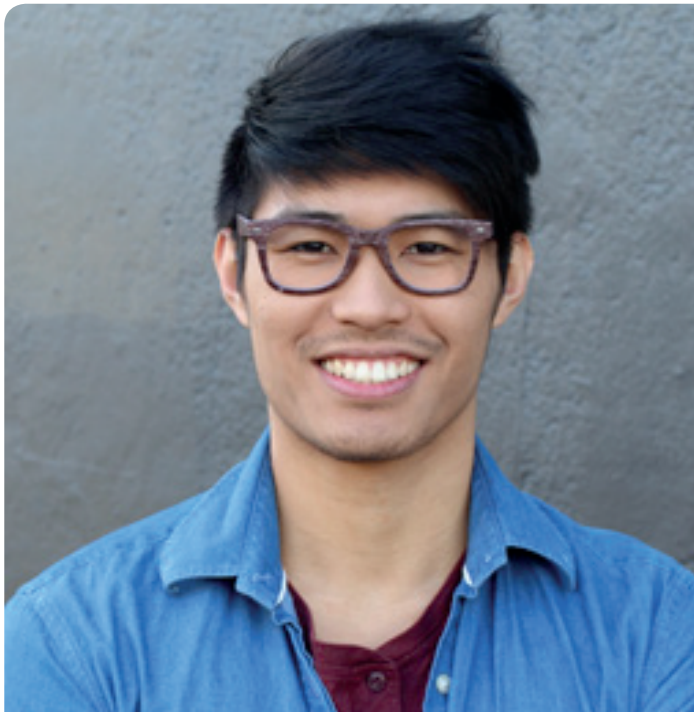
University Hospitals

2019
Community Health Implementation Strategy

UH Elyria Medical Center –
Specialty Hospital of Lorain
Lorain County





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Adoption by the Board

University Hospitals adopted the UH Elyria Medical Center-Specialty Hospital of Lorain Community Health Implementation Strategy on March 20, 2019.

Community Health Implementation Strategy Availability

The Implementation Strategy can be found on University Hospitals' website at www.UHhospitals.org/CHNA-IS or a hard copy can be mailed upon request at CommunityBenefit@UHhospitals.org.

Written Comments

Individuals are encouraged to submit written comments, questions or other feedback about the UH Elyria Medical Center-Specialty Hospital of Lorain Implementation Strategy to CommunityBenefit@UHhospitals.org. Please be 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.

Glossary

State Assessments and Plans

SHA (State Health Assessment)—A health assessment conducted by the state of Ohio to measure the health status of Ohioans. It is conducted every 3 years. The data collected from a SHA informs the state health improvement plan (SHIP).

SHIP (State Health Improvement Plan)—An improvement plan conducted by the state of Ohio that contains priorities, strategies, and measurable indicators to address health needs identified in the SHA. The SHIP is conducted every 3 years and serves as a guide for local improvement plans and hospital implementation strategies.

Hospital Assessments and Strategies

CHNA (Community Health Needs Assessment)—A health assessment conducted by hospitals to measure the health status of the population. It is required by Section 501(r) of the Internal Revenue Code and conducted every 3 years. The data collected from a CHNA informs the implementation strategy (IS).

IS (Implementation Strategy)—A hospital plan that identifies priorities, strategies, and measurable indicators to address health needs identified in the CHNA. It is required by Section 501(r) of the Internal Revenue Code and conducted every 3 years. IS's are required to align with the SHIP beginning in 2020.

Local Health Department (LHD) Assessments and Plans

CHA (Community Health Assessment)—A collaborative, county-level health assessment conducted by the health department and other community members to measure the health status of the population. It is required by the Public Health Accreditation Board (PHAB) and is conducted every 3 years in Ohio. The data collected from a CHA informs the community health improvement plan (CHIP).

CHIP (Community Health Improvement Plan)—A collaborative, county-level improvement plan conducted by the health department and other community members that identifies priorities, strategies, and measurable indicators to address health needs identified in the CHA. It is required by the Public Health Accreditation Board (PHAB) and is conducted every 3 years in Ohio. CHIP's are required to align with the SHIP beginning in 2020.

Miscellaneous

Ohio state law (ORC 3701.981)—A state law that requires all hospitals to collaborate with their local health departments on CHAs and CHIPs.

PHAB (Public Health Accreditation Board)—A national body that issues accreditation to health departments based on a set of standards. All health departments in Ohio are mandated to become accredited by 2020.

Acronyms

National, State, and Local Organizations

CDC—Centers for Disease Control and Prevention

ODH—Ohio Department of Health

HCNO—Hospital Council of Northwest Ohio

UH—University Hospitals

Miscellaneous

BRFSS—Behavioral Risk Surveillance System

YRBSS—Youth Risk Behavior Surveillance System

MAPP—Mobilizing for Planning and Partnerships

CHR—County Health Rankings

Introduction

In 2018, University Hospitals Elyria Medical Center and Specialty Hospital of Lorain (the "Hospitals") conducted a joint community health needs assessments (a "CHNA") compliant with the requirements of Treas. Reg. §1.501(r) ("Section 501(r)") and Ohio Revised Code ("ORC") 3701.981. The 2018 CHNA 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. The IS identifies the means through which the Hospitals plan to address a number of the needs that are consistent with the Hospitals' charitable mission as part of their community benefit programs. Additionally, the Hospitals are addressing some of these needs simply by providing care to all, regardless of ability to pay, every day. The Hospitals anticipate that the strategies may change and therefore, a flexible approach is best suited for the development of its response to the 2018 CHNA. For example, certain community health needs may become more pronounced and require changes to the initiatives identified by the Hospitals in the IS. More specifically, since this IS was done in conjunction with the existing Lorain County Community Health Improvement Plan, other community organizations will be addressing certain needs.

In addition, the Hospitals worked together to align both their CHNA and IS with state plans. Ohio state law (ORC 3701.981) mandates that all hospitals must collaborate with their local health departments on community health assessments (a "CHA") and community health improvement plans (a "CHIP"). Additionally, local hospitals must align with the Ohio State Health Assessment (a "SHA") and Ohio State Health Improvement Plan (a "SHIP"); see Appendix A. This requires alignment of the CHNA and IS process timeline, indicators, and strategies. This local alignment must take place by October 2020.

> *Note: This symbol will be used throughout the report when a priority, indicator, or strategy directly aligns with the 2017-2019 SHIP. This symbol, the Lorain County outline, will be used throughout the report when a priority, indicator, or strategy directly aligns with the 2014-2019 CHIP.*

This aligned approach has resulted in less duplication, increased collaboration, and sharing of resources. This report serves as the initial IS to move the Hospitals into a more collaborative approach with county partners. As a result of this alignment, the Hospitals will be actively participating in the upcoming 2019 Lorain County CHA and CHIP process, which will align partners to be in compliance by 2020.

University Hospitals Health Systems, Inc. ("University Hospitals" or "UH"), contracted with the Hospital Council of Northwest Ohio ("HCNO") to align the 2019 IS with the existing 2014-2019 Lorain County CHIP and the 2017-2019 SHIP.

HCNO guided the process and reviewed sources of primary data including the 2018 CHNA, 2016 hospital utilization and discharge data, the previous Hospitals' IS, and the 2017 evaluation of impact. In addition, the Hospitals closely considered the 2014-2019 Lorain County CHIP and 2017 Annual CHIP update when identifying strategies.

The goal was to identify strategies to address the priorities identified in the 2018 UH Elyria Medical Center-Specialty Hospital of Lorain CHNA, being mindful of any new data or nuances that may have occurred since the CHNA was adopted. The following priorities were identified in the 2018 UH Elyria Medical Center-Specialty Hospital of Lorain CHNA: access to care, expand coordinated education and prevention services (includes infant mortality), improving mental health, improving obesity/weight control, and improving substance use and abuse – which mirror the priorities in the Lorain County CHIP. To align with the language in the Ohio SHIP, these priorities have been reorganized and will be referred to more concisely as mental health and addiction, and chronic disease.

Hospital Mission Statement

As a wholly owned subsidiary of University Hospitals, UH Elyria Medical Center is 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”).

Specialty Hospital of Lorain is a not for profit joint venture of Mercy Regional Health System, UH Elyria Medical Center, and Grace Hospital. It is a long term acute care hospital that provides acute care services for patients who are medically complex, critically ill, and require an extended period of hospitalization. Its mission is to extend the healing ministry of Jesus by improving the health of our community with emphasis on those who need long term acute care.

Community Served by the Hospital

The community has been defined as Lorain County. Most (91%) of University Hospitals Elyria Medical Center’s discharges and 93% of Specialty Hospital of Lorain’s discharges were Lorain County residents. In addition, University Hospital collaborates with multiple stakeholders, most of which provide services at the county-level. For these two reasons, the county was defined as the community.

2018 CHNA Observations

Data Observations

The 2018 UH Elyria Medical Center-Specialty Hospital of Lorain CHNA is a 192-page report that consists of county-level primary and secondary data for Lorain County. The following data are key findings from the CHNA that 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 or https://www.specialtyhospitaloflorain.org/community-needs-assessment.html

- In 2015, 11% of adults were uninsured, increasing to 23% of those with incomes less than $25,000 and 26% of those under the age of 30.
- In 2015, 18% of Lorain County adults did not have at least one person they thought of as their personal doctor or healthcare provider.
- Three percent (3%) of Lorain County adults considered attempting suicide in 2015.
- According to the Ohio Department of Health (ODH), the suicide death rate for Lorain County was 14.4 per 100,000 population (age-adjusted) from 2012-2017.
- In 2015, 10% of Lorain County adults had used marijuana in the past 6 months, increasing to 20% of those with incomes less than $25,000 and 29% of those under the age of 30.
- Eleven percent (11%) of adults had used medication not prescribed for them or they took more than prescribed to feel good or high and/or more active or alert during the past 6 months, increasing to 17% of those with incomes less than $25,000
- From 2012-2017, there were 32.5 unintentional resident drug overdose deaths per 100,000 population (age-adjusted) in Lorain County, according to ODH.
- More than two-thirds (69%) of Lorain County adults were either overweight (32%) or obese (37%) by Body Mass Index (BMI) in 2015.

- Five percent (5%) Lorain County adults did not have any servings of fruits and vegetables on the average day in 2015.
- Nearly one in four (23%) adults did not participate in any physical activity in the past week, including 2% who were unable to exercise, in 2015.
- Twenty-two percent (22%) Lorain County adults were current smokers in 2015.
- In 2015, 45% of current smokers responded that they had stopped smoking for at least one day in the past year because they were trying to quit smoking.
- In 2015, 6% of adults reported they had angina or coronary heart disease, increasing to 15% of those over the age of 65.
- In 2015, 11% of Lorain County adults had been diagnosed with diabetes, increasing to 16% of those with incomes less than $25,000 and 24% of those over the age of 65

2018 CHNA Adult Trend Summary Table

Adult Variables	Lorain County 2011	Lorain County 2015	Ohio 2016	U.S. 2016
Health Status				
Rated health as excellent or very good	48%	47%	51%	52%
Rated general health as fair or poor	12%	14%	18%	17%
Rated their mental health as not good on four or more days	20%	27%	N/A	N/A
Average days that physical health not good in past month	N/A	3.1	3.7‡	3.8‡
Average days that mental health not good in past month	N/A	4.1	4.0‡	3.8‡
Health Care Access and Utilization				
Visited the doctor's office when needed health care services or advice	75%	80%	N/A	N/A
Had one person they thought of as their personal doctor or healthcare provider	52%	52%	83%	77%
Did not see a doctor in the past year due to cost	20%	18%	11%	12%
Visited a doctor for a routine checkup in the past year	55%	64%	75%	71%
Health Care Coverage				
Uninsured	11%	11%	7%	10%
Arthritis, Asthma & Diabetes				
Had been diagnosed with arthritis	35%	34%	31%	26%
Had been diagnosed with asthma	14%	15%	14%	14%
Had been diagnosed with diabetes	13%	11%	11%	11%
Cardiovascular Health				
Had angina or coronary heart disease	6%	6%	5%	4%
Had a heart attack	6%	3%	5%	4%
Had a stroke	2%	4%	4%	3%
Had been diagnosed with high blood pressure	35%	36%	34%*	31%*
Had been diagnosed with high blood cholesterol	36%	33%	37%*	36%*
Had blood cholesterol checked within the past 5 years	N/A	82%	78%*	78%*

N/A - Not available

Cancer				
Diagnosed with cancer	13%	11%	N/A	N/A
Alcohol Consumption				
Current drinker (drank alcohol at least once in the past month)	59%	61%	53%	54%
Binge drinker (defined as consuming more than four [women] or five [men] alcoholic beverages on a single occasion in the past 30 days)	23%	11%	18%	17%

**2015 BRFSS*

‡2015 BRFSS Data as compiled by 2017 County Health Rankings

Indicates alignment with the Ohio State Health Assessment

Adult Variables	Lorain County 2011	Lorain County 2015	Ohio 2016	U.S. 2016
Tobacco Use				
Current smoker (currently smoke some or all days)	22%	22%	23%	17%
Former smoker (smoked 100 cigarettes in lifetime & now do not smoke)	26%	23%	24%	25%
Drug Use				
Adults who used marijuana in the past 6 months	7%	10%	N/A	N/A
Adults who used heroin in the past 6 months	1%	<1%	N/A	N/A
Adults who misused prescription drugs in the past 6 months	11%	11%	N/A	N/A
Sexual Behavior				
Had more than one sexual partner in past year	6%	8%	N/A	N/A
Weight Status				
Overweight	35%	32%	35%	35%
Obese	32%	37%	32%	30%
Quality of Life				
Limited in some way because of physical, mental or emotional problem	20%	36%	21%*	21%*
Mental Health				
Considered attempting suicide in the past year	4%	3%	N/A	N/A
Two or more weeks in a row felt sad, blue or depressed	<1%	1%	N/A	N/A
Oral Health				
Adults who have visited the dentist in the past year	60%	66%	68%	66%
Preventive Medicine				
Had a pneumonia vaccine (age 65 and older)	N/A	82%	75%	73%
Had a flu vaccine in the past year (ages 65 and over)	68%	82%	57%	58%
Had a mammogram in the past two years (age 40 and older)	79%	75%	74%	72%
Had a Pap smear in the past three years	N/A	68%	82%¥	80%¥

Had a PSA test within the past two years (age 40 & over)	N/A	60%	39%	40%
Had a PSA test within the past year	32%	27%	N/A	N/A
Had a digital rectal exam within the past year	26%	17%	N/A	N/A
Social Determinants of Health				
Firearms kept in or around their home	24%	31%	N/A	N/A

N/A - Not available
**2015 BRFSS*
¥BRFSS for both Ohio and U.S. reports for women ages 21-65
Indicates alignment with the Ohio State Health Assessment

2018 CHNA Youth Trend Summary Table

Youth Variables	Lorain County 2014 6th grade	Lorain County 2014 8th grade	Lorain County 2014 10th grade
Weight Control			
Physically active at least 60 minutes per day on every day in past week	27%	30%	25%
Physically active at least 60 minutes per day on 5 or more days in past week	48%	52%	48%
Did not participate in at least 60 minutes of physical activity on at least 1 day	12%	9%	11%
Watched TV 3 or more hours per day	33%	32%	29%
Tobacco Use			
Smoked cigarettes in the past year	2%	10%	17%
Current smokers	2%	7%	11%
Alcohol Consumption			
Youth who had alcohol in the past year	4%	19%	40%
Current drinker	2%	10%	22%
Rode with someone who was drinking	8%	15%	12%
Drank and drove (of youth drivers)	N/A	1%	2%
Drug Use			
Used marijuana in the past month	2%	7%	13%
Used methamphetamines in the past year	1%	1%	1%
Used cocaine in the past year	1%	1%	1%
Used heroin in the past year	1%	1%	1%
Used steroids in the past year	1%	1%	2%
Used inhalants in the past year	1%	2%	2%
Used ecstasy/MDMA in the past year	<1%	1%	2%
Used prescription drugs not prescribed for them in the past month	1%	3%	4%
Mental Health			
Youth who had seriously considered attempting suicide in the past year	8%	15%	17%
Youth who had attempted suicide in the past year	5%	7%	6%

N/A - Not available

Youth who felt sad or hopeless almost every day for 2 or more weeks in a row	20%	27%	36%
Safety and Violence			
Youth who carried a knife, club or other weapon at school	4%	6%	7%
Youth who had been threatened with a handgun, knife or club	6%	8%	5%
Youth who threatened to hurt another student by hitting, slapping or kicking	17%	29%	24%
Youth who always wore a seatbelt when driving a car	N/A	N/A	43%

Priority Health Needs

Reminder: This symbol , will be used throughout the report when a priority, indicator, or strategy directly aligns with the 2017-2019 SHIP. This symbol , the Lorain County outline, will be used throughout the report when a priority, indicator, or strategy directly aligns with the 2014-2019 CHIP.

Priorities:

1. Mental Health and Addiction (formerly referred to as improving mental health and substance abuse)
2. Chronic Disease (formerly referred to as improving obesity and weight control)

Significant Health Needs Not Being Addressed by the Hospital

The Hospitals are not directly addressing access to care or prevention as stand-alone priorities in their 2019 IS although aspects of these needs are encompassed in efforts to address mental health/addiction and chronic disease. This decision is based on several factors:

1. The 2019 IS is a one-year plan because the Hospitals and public health department will be conducting a new, joint CHNA, in 2019. As such the hospitals made a deliberate decision to target efforts around access and prevention to mental and health/addiction and chronic disease based on the magnitude and severity of these conditions and available resources;

2. Other Lorain County partners are implementing strategies focused on improving access to dental care for the uninsured, transportation, access to prescriptions and substance abuse treatment services for youth; and

3. Other Lorain County partners are addressing prevention via: prenatal and newborn home visits; community outreach to raise awareness about maternal and infant health and associated resources; specific programs like Moms and Babies First and Cribs for Kids to assist families; Botvins Lifeskills programming in schools; and tobacco-free advocacy and cessation programs.

Strategies to Address Health Needs

An ad hoc IS committee was convened in July 2018 to solicit input from key staff at the Hospitals, affiliated community partners, and members of the Lorain County CHA-CHIP planning team. This committee was assembled to identify potential strategies that the Hospitals will execute in view of lessons learned and current opportunities. To do this, the committee reviewed various sources of data including primary data from the 2018 CHNA, hospital utilization and discharge data from 2016, the evaluation of impact, and the previous 2016 IS. The committee agreed to build upon the efforts of the previous IS. Therefore, the following strategies, goals and objectives were developed:

Priority 1: Mental Health and Addiction

Priority #1: Mental Health and Addiction				
Strategy 1: Cell phone-based support programs				
Goal: Increase awareness of suicide among adults and youth.				
Objective: Promote the Crisis Text Line in at least two new additional ways by January 1, 2020.				
Action Step	Priority Population	Responsible Party/ Collaborator	Timeline	Indicator(s) to measure impact of strategy:
Year 1: Work with the Lorain County Suicide Prevention Coalition and the Board of Mental Health to raise awareness of the Crisis Text Line (Text 4hope to 741741) throughout the county. Promote the Crisis Text Line in at least two new additional ways including welcome folders given at hospital admission, information distributed at community events and mailing a printed resource guide. Disseminate information to the schools through health fairs.	Adults and youth	UH Elyria Medical Center and Lorain County Suicide Prevention Coalition	January 1, 2020.	Reduce suicide deaths: Number of deaths due to suicide per 100,000 populations (age adjusted) *(Source for Data: ODH Public Health Data Warehouse)*

Type of Strategy:

- ○ Social determinants of health
- ⊗ Public health system, prevention and health behaviors
- ○ Healthcare system and access
- ○ Strategy is not specific to the SHIP

Strategy identified as likely to decrease disparities?

- ○ Yes
- ⊗ No
- ○ Strategy is not specific to the SHIP

Resources to address strategy:

- Hospital-level resources: Staff time, materials, and printing costs
- Community-level resources: Lorain County Suicide Prevention Coalition

Priority #1: Mental Health and Addiction

Strategy 2: Emergency room and first responder overdose response training (Naloxone Access)

Goal: Increase awareness of response strategies to opioid overdoses.

Objective: Train emergency department staff, staff responders, and first responders on opioid overdose response strategies through four educational sessions by January 1, 2020.

Action Step	Priority Population	Responsible Party/ Collaborator	Timeline	Indicator(s) to measure impact of strategy:
Year 1: Utilizing SAMHSA's *Opioid Overdose Prevention Toolkit: Five Essential Steps for First Responders,* or another evidence-based program or toolkit, such as Project DAWN, train UH emergency department staff, staff responders, and first responders on how to respond to and treat an opioid overdose, such as the use of naloxone. Increase awareness of free naloxone distribution for lay responders.	Adult	UH Elyria Medical Center	January 1, 2020	1. Reduce overdose deaths: Number of overdose-related deaths for EMS/Emergency Room 2. Increase referrals: Number of referrals to treatment *(Sources for Data: UH)*

Type of Strategy:

- ○ Social determinants of health
- ○ Public health system, prevention and health behaviors
- ⊗ Healthcare system and access
- ○ Strategy is not specific to the SHIP

Strategy identified as likely to decrease disparities?

- ○ Yes
- ⊗ No
- ○ Strategy is not specific to the SHIP

Resources to address strategy:

- Hospital-level resources: Staff time, training materials, space
- Community-level resources: Lorain County Alcohol, Drug and Addiction Services, Lorain County Health Department

Priority #1: Mental Health and Addiction				
Strategy 3: Community-wide care coordination				
Goal: Create a mental health/substance abuse treatment coalition.				
Objective: Create a Hospital Opiate Coalition with mental health/substance abuse partners by January 1, 2020.				
Action Step	Priority Population	Responsible Party/Collaborator	Timeline	Indicator(s) to measure impact of strategy:
Year 1: Invite faith-based leaders, local businesses, community organizations, justice system liaisons, mental health/substance abuse service providers, health care providers, and other organizations to have a round-table discussion surrounding mental health and substance abuse in Lorain County. Coordinate implementation of coalition with the Specialty Hospital of Lorain. Compile comprehensive baseline data regarding what programs and services are offered within the county, and address gaps in care coordination.	Adult	UH Elyria Medical Center and Specialty Hospital of Lorain	January 1, 2020	Increase referrals: Number of referrals to mental health and substance abuse treatment *(Source for Data: UH and Specialty Hospital of Lorain)*
Type of Strategy: ○ Social determinants of health ○ Public health system, prevention and health behaviors ○ Healthcare system and access ⊗ Strategy is not specific to the SHIP				
Strategy identified as likely to decrease disparities? ○ Yes ○ No ⊗ Strategy is not specific to the SHIP				
Resources to address strategy: • Hospital-level resources: Staff time, space and meeting expenses • Community-level resources: Community expertise and time				

Priority 2: Chronic Disease

Priority #2: Chronic Disease				
Strategy 1: Prediabetes (and obesity) screening and referral				
Goal: Prevent diabetes in adults.				
Objective: By January 1, 2020, increase referrals with diagnosis of prediabetes and obesity by 5%.				
Action Step	Priority Population	Responsible Party/Collaborator	Timeline	Indicator(s) to measure impact of strategy:
Year 1: Continue to implement prediabetes and obesity screening and referral. Increase obesity referrals by 5%.	Adults	UH Elyria Medical Center	January 1, 2020	1. Increase screenings: Number of people screened for BMI and A1C *(Sources for Data: UH)* 2. Decrease diabetes: Percent of adults who have been told by a health professional that they have diabetes *(Source for Data: CHNA and BRFSS)*

Type of Strategy:

- ○ Social determinants of health
- ○ Public health system, prevention and health behaviors
- ⊗ Healthcare system and access
- ○ Strategy is not specific to the SHIP

Strategy identified as likely to decrease disparities?

- ○ Yes
- ⊗ No
- ○ Strategy is not specific to the SHIP

Resources to address strategy:

- Hospital-level resources: Staff time, screening supplies, and event materials
- Community-level resources: Counseling and materials by American Diabetes Association (ADA)

Priority #2: Chronic Disease

Strategy 2: Diabetes awareness classes

Goal: Increase awareness of diabetes prevention and self-management.

Objective: By January 1, 2020, increase enrollment in diabetes education programs by 5%.

Action Step	Priority Population	Responsible Party/ Collaborator	Timeline	Indicator(s) to measure impact of strategy:
Year 1: Continue to implement diabetes education programs. Increase enrollment in diabetes education programs by 5%. Provide adult education on nutrition, exercise, glucose monitoring, eye exams and foot care. Additionally, meet with school superintendents and community agency leaders to educate them on the importance of a healthy diet and discuss implementing the MyPlate program, or another evidence-based nutrition program, in all school districts. Provide 3 new opportunities for screenings in community for the underserved population.	Adults	UH Elyria Medical Center	January 1, 2020	1. Reduce adult diabetics who are overweight or obese: Percent of diabetics ages 19+ that report body mass index (BMI) greater than or equal to 25 *(Source for Data: UH)* 2. Decrease diabetes: Percent of adults who have been told by a health professional that they have diabetes *(Source for Data: CHNA and BRFSS)*

Type of Strategy:

- ○ Social determinants of health
- ○ Public health system, prevention and health behaviors
- ○ Healthcare system and access
- ⊗ Strategy is not specific to the SHIP

Strategy identified as likely to decrease disparities?

- ○ Yes
- ○ No
- ⊗ Strategy is not specific to the SHIP

Resources to address strategy:

- Hospital-level resources: Staff time, printed materials, screening supplies
- Community-level resources: USDA, MyPlate website and materials, access to school personnel

Priority #2: Chronic Disease

Strategy 3: Community fitness programs

Goal: Decrease adult obesity.

Objective: By January 1, 2020, implement at least one additional community fitness program through the United We Sweat campaign.

Action Step	Priority Population	Responsible Party/Collaborator	Timeline	Indicator(s) to measure impact of strategy:
Year 1: Continue to work with community partners to implement the United We Sweat campaign. Implement at least one additional community fitness program through the United We Sweat campaign to an underserved population such as Boys and Girls Club of Lorain and El Centro.	Adult	UH Elyria Medical Center, Avon Recreation Center	January 1, 2020	Decrease physical inactivity: Percentage of adults reporting no leisure time physical activity *(Source for Data: CHNA and BRFSS)*

Type of Strategy:

- ○ Social determinants of health
- ⊗ Public health system, prevention and health behaviors
- ○ Healthcare system and access
- ○ Strategy is not specific to the SHIP

Strategy identified as likely to decrease disparities?

- ○ Yes
- ⊗ No
- ○ Strategy is not specific to the SHIP

Resources to address strategy:

- Hospital-level resources: Staff time
- Community-level resources: Avon recreational center space and equipment, Boys and Girls Club of Lorain, and El Centro

Community Collaborators

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

- Danielle Price, University Hospitals
- Elyse Bierut, University Hospitals
- Kim Horvath, University Hospitals
- Sue Keller, University Hospitals
- Paul Forthofer, University Hospitals
- Michelle Hennis, Specialty Hospital of Lorain
- Susan Adams, Specialty Hospital of Lorain
- Stephanie Lesco, Lorain County Public Health

This IS was facilitated and written by Britney Ward, Director of Community Health Improvement, and Emily Golias, Community Health Improvement Coordinator, of the Hospital Council of Northwest Ohio.

This IS will be implemented in collaboration with other entities including, but not limited to:

- Boy and Girls Club of Lorain
- El Centro
- Lorain Area City Schools
- Lorain County Alcohol, Drug and Addiction Services
- Lorain County Children's Services
- Lorain County Department of Job and Family Services
- Lorain County Family YMCA Buckeye Local Schools
- Lorain County Head Start
- Lorain County Health Department
- Lorain County Mental Health Recovery Services Board
- Lorain County Prevention Coalition
- Lorain County Substance Abuse Leadership Team
- Specialty Hospital of Lorain
- Lorain Senior Center
- Lorain Senior Protection and Advocacy Network
- UH Avon Health Center

Qualifications of Consulting Company

This IS was facilitated and written by Britney Ward, Director of Community Health Improvement, and Emily Golias, Community Health Improvement Coordinator, of the Hospital Council of Northwest Ohio.

The Hospital Council of Northwest Ohio (HCNO) is a 501(c)(3) non-profit regional hospital association founded in 1972 that represents and advocates on behalf of its member hospitals and health systems and provides collaborative opportunities to enhance the health status of the citizens of Northwest Ohio. HCNO is respected as a neutral forum for community health improvement. HCNO has a track record of addressing health issues and health disparities collaboratively throughout northwest Ohio, and the state. Local and regional initiatives include: county-wide health assessments, community health improvement planning, strategic planning, disaster preparedness planning, Northwest Ohio Regional Trauma Registry, Healthcare Heroes Recognition Program and the Northwest Ohio Pathways HUB.

The Community Health Improvement division of HCNO has been conducting community health assessments (CHAs), community health improvement plans (CHIPs), and facilitating outcome focused multi-sectorial collaborations since 1999. HCNO has completed more than 90 CHAs in 44 counties. The model used by HCNO can be replicated in any type of county and therefore has been successful at the local and regional level, as well as for urban, suburban, and rural communities.

The HCNO Community Health Improvement Division has six full time staff members with Master's Degrees in Public Health (MPH), that are dedicated solely to CHAs, CHIPs, and other community health improvement initiatives. HCNO also works regularly with professors at the University of Toledo, along with multiple graduate assistants to form a very experienced and accomplished team. The HCNO team has presented at multiple national, state, and local conferences including the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS) conference, the Association of Community Health Improvement (ACHI) national conference, the Ohio Hospital Association (OHA) state conference, the Ohio Association of Health Commissioners (AOHC), and others.

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Appendix A

Ohio State Health Improvement Plan (SHIP)

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

SHIP Overview

The Hospitals closely considered the 2017-2019 State Health Improvement Plan (SHIP) 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)

SHIP Priorities

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)

Cross-cutting Factors

The SHIP also takes a comprehensive approach to improving Ohio's greatest health priorities by identifying cross-cutting factors that impact multiple outcomes. Rather than focus only on disease-specific programs, the SHIP highlights powerful underlying drivers of wellbeing, such as student success, housing affordability and tobacco prevention. This approach is built upon the understanding that access to quality health care is necessary, but not sufficient, for good health. The SHIP is designed to prompt state and local stakeholders to implement strategies that address the social determinants of health and health behaviors, as well as approaches that strengthen connections between the clinical healthcare system, public health, community-based organizations and sectors beyond health.

SHIP planners drew upon this framework to ensure that the SHIP includes outcomes and strategies that address the following cross-cutting factors:

- Health equity: Attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and

healthcare disparities.

- Social determinants of health: Conditions in the social, economic and physical environments that affect health and quality of life.

- Public health system, prevention and health behaviors:
    - The public health system is comprised of government agencies at the federal, state, and local levels, as well as nongovernmental organizations, which are working to promote health and prevent disease and injury within entire communities or population groups.
    - Prevention addresses health problems before they occur, rather than after people have shown signs of disease, injury or disability.
    - Health behaviors are actions that people take to keep themselves healthy (such as eating nutritious food and being physically active) or actions people take that harm their health or the health of others (such as smoking). These behaviors are often influenced by family, community and the broader social, economic and physical environment.

- Healthcare system and access: Health care refers to the system that pays for and delivers clinical health care services to meet the needs of patients. Access to health care means having timely use of comprehensive, integrated and appropriate health services to achieve the best health outcomes.

Alignment with the 2017-2019 SHIP

Beginning in 2020, IS's will be 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 SHIP (see Figure 1.1 on the next page). While SHIP-alignment is not a requirement for the 2019 IS, the SHIP was used as a guide in the creation of this document. The following 2019 IS priority topics, priority outcomes, cross cutting factors and cross-cutting outcomes very closely align with the 2017-2019 SHIP priorities:

2019 IS Alignment with the 2017-2019 SHIP			
Priority Topic	***Priority Outcome***	***Cross-Cutting Strategy***	***Cross-Cutting Outcome***
Mental health and addiction	• Decrease suicide deaths	• N/A	• N/A
Chronic Disease	• Decrease adult diabetes		

Figure 1.1. State Health Improvement Plan (SHIP) Overview