



University Hospitals

2020-2022 Community Health Implementation Strategy

UH Ahuja Medical Center

Beachwood RH, LLC

UH Bedford Medical Center

UH Cleveland Medical Center

UH Parma Medical Center

UH Rainbow Babies & Children's Hospital

UH Richmond Medical Center

UH St. John Medical Center

Cuyahoga County, Ohio



Table of Contents

Board Adoption	2
Community Health Implementation Strategy Availability	2
Written Comments	2
Cuyahoga County Community Health Steering Committee	2
Hospital Mission Statement	3
Introduction	3
Alignment with Local and State Standards	3
2019 Joint Cuyahoga Community Health Needs Assessment (CHNA) Observations	5
Community Served by Hospitals	7
Priority Health Needs	7
Strategies to Address Health Needs	8
UH Ahuja Medical Center	9
Beachwood RH, LLC (UH Rehabilitation Hospital)	16
UH Regional Hospitals (UH Bedford & Richmond Medical Centers)	19
UH Cleveland Medical Center	23
UH Parma Medical Center	37
UH Rainbow Babies & Children's Hospital	41
UH St. John Medical Center	47
Other UH Community Health Initiatives	52
Emerging Initiatives (County-Aligned Strategies)	56
Significant Health Needs Not Being Addressed by the Hospital	59
Community Collaborators	59
Qualifications of Consulting Company	61
Contact Information	62
Appendix A: UH Resource Matrix	63
Appendix B: 2020-2022 Inventory of Current Stakeholder-Specific Programs	67

Adoption by the Board

University Hospitals adopted the 2020-2022 Community Health Implementation Strategy on March 31, 2020. It includes the following UH facilities located in Cuyahoga County, collectively referred to in this report as (the “Hospitals”):

- 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
- University Hospitals St. John Medical Center

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 Implementation Strategy 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.

Cuyahoga County Community Health Steering Committee:

Better Health Partnership
Case Western Reserve University School of Medicine
Cleveland Department of Public Health
Cleveland Clinic
Cuyahoga County Board of Health
Cypress Research Group
Health Improvement Partnership-Cuyahoga
PolicyBridge
Southwest General Health Center
St. Vincent Charity Medical Center
The Center for Health Affairs
The MetroHealth System
United Way of Greater Cleveland
University Hospitals

Hospital Mission Statement

As wholly owned subsidiaries 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.

* Beachwood RH, LLC (UH Rehabilitation Hospital) is a joint venture between University Hospitals and Kindred Healthcare Corporation. Its mission is to promote healing, provide hope, preserve dignity and produce value for each patient, family member, customer and employee they serve.

Introduction


In 2019, 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, (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 2019 Joint Cuyahoga CHNA represented a powerful collaboration between Better Health Partnership, Case Western Reserve University School of Medicine, the Cleveland Department of Public Health, the Cuyahoga County Board of Health, Health Improvement Partnership-Cuyahoga (HIP-Cuyahoga), The MetroHealth System, PolicyBridge, Southwest General Health Center, St. Vincent Charity Medical Center, The Center for Health Affairs, United Way of Greater Cleveland and University Hospitals (Cuyahoga Community Health Partners).

The 2019 Joint Cuyahoga County CHNA served as the foundation for developing University Hospital’s 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 UH’s charitable mission as part of its community benefit programs. Likewise, the Hospitals are addressing some of these needs simply by providing care to all, regardless of ability to pay, every day. They anticipate that the strategies may change and therefore, a flexible approach is best suited for the development of its response to the 2019 Joint Cuyahoga County 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 Cuyahoga Community Health Partners, other community organizations will be addressing certain needs.

Alignment with Local and State Standards

The Hospitals worked together to align their 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 Ohio’s State Health Assessment (“SHA”)

and State Health Improvement Plan (a “SHIP”). 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 report serves as the 2020-2022 Joint University Hospitals Implementation Strategy for UH Ahuja Medical Center, Beachwood RH, LLC (UH Rehabilitation Hospital), UH Regional Hospitals (Bedford and Richmond Campuses), UH Cleveland Medical Center, The Parma Community General Hospital Association d/b/a UH Parma Medical Center, UH Rainbow Babies & Children’s Hospital, and UH St. John Medical Center. It aligns with the strategies and plans underway by the other Cuyahoga County hospital systems and public health departments engaged in the 2020-2022 community health improvement process and meets the state of Ohio’s October 1, 2020 deadline.

Per requirements set forth in Section 501(r), a collaborating hospital facility meets the requirements for a joint implementation strategy, if the strategy (i) is clearly identified as applying to the hospital facility; (ii) clearly identifies the hospital facility’s particular role and responsibilities in taking the actions described in the implementation strategy and the resources the hospital facility plans to commit to such actions; and (iii) includes a summary or other tool that helps the reader easily locate those portions of the joint implementation strategy that relate to the hospital facility.¹ This IS meets all of these requirements and was developed to more clearly delineate the commitments made by University Hospitals to the overall community health improvement effort underway in Cuyahoga County.

Alignment among Cuyahoga Community Health Partners:

The Cuyahoga County Community Health Partners identified shared priorities, two aligned strategies and a set of shared indicators for each of the five priority areas which are outlined in this report.

The Hospitals are working with other partners in Cuyahoga County to address the following priorities which were identified in the 2019 Joint Cuyahoga County CHNA:

1. Eliminating structural racism*
2. Enhancing trust and trustworthiness across sectors, people and communities*
3. Addressing community conditions, such as reducing poverty and its effects
4. Enhancing mental health and reducing substance abuse
5. Reducing chronic illness and its effects

** Long-term, cross-cutting needs that are both stand-alone priorities and also undergird each of the other identified needs.*

¹ Internal Revenue Service, Department of Treasury. Federal Register, Volume 79, No. 250. Effective December 29, 2014. Section. 501r-3(c)(4).

2019 Joint Cuyahoga CHNA Observations

The 2019 Joint Cuyahoga County CHNA is a 176-page report that consists of county-level primary and secondary data for Cuyahoga County. The following data are observations from the CHNA that support the priorities and strategies found in this IS. The full CHNA report can be found at: www.UHhospitals.org/CHNA-IS.

The following data and themes are key findings from the CHNA that deepened understanding of the current health needs and health inequities in Cuyahoga County and support the priorities and strategies found in this Implementation Strategy (IS).

1. A tremendous wealth of community assets and health care resources exist in Cuyahoga County, yet **stark inequities in health are experienced by its residents**.
 - a. The conditions that shape health (commonly referred to as the social and environmental determinants of health) – such as financial resources, access to healthy food, and safe and affordable housing, to name a few – are not spread equitably, resulting in significant differences in health outcomes, such as disease severity, life expectancy and infant mortality. These differences are shaped by long-standing systems and structures that impact the conditions in which residents live, work, learn and play.

2. **Current differences in health outcomes across various neighborhoods within Cuyahoga County are the direct result of systems, structures, and policies, such as red-lining, that over many decades have limited opportunities and impacted health for residents of color in those communities**.
 - a. The 2019 Joint Cuyahoga County CHNA represents a new era in working across boundaries to build on community strengths to address the most pressing and challenging determinants of health for all who live, learn, work and play in Cuyahoga County.
 - b. Significant work to enhance trust and trustworthiness across sectors, people and communities is necessary to ensure all Cuyahoga County residents have an equal opportunity to achieve their fullest potential.
 - c. Structural racism was identified as the underlying issue that globally affects health which must be addressed in order to impact inequity and improve health outcomes.

3. **The strongest indicator we have of health status is poverty**. The 2019 Joint Cuyahoga County Community Health Assessment identified several inequities in access to care and health outcomes based on socioeconomic status:
 - a. One-third (33%) of city of Cleveland residents lived below the poverty line in 2017, compared to 18.0% of county residents, as a whole².

² U.S. Census Bureau. American Community Survey, 2017, 1 Year Estimates, Table S1701. Accessed May 24, 2019 from <http://factfinder2.census.gov>. Data now available at: <https://data.census.gov/cedsci/>.

- b. Cuyahoga County families with incomes below \$25,000 have higher rates of children diagnosed with asthma (27.3%) compared to those with incomes above \$25,000 (13.7%) according to survey results³.
4. 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 higher (204.4 per 100,000) than for the state (186.2) and the U.S. overall (165.0). African Americans had the highest cardiovascular mortality rate among all racial/ethnic groups in Cuyahoga County overall (254.8)⁴.
 - b. Among survey respondents, 12.7% of Cuyahoga County adults have been told by a medical professional that they have **diabetes**. Rates are significantly higher among Black non-Hispanic residents (25.8%) compared to White non-Hispanic residents (7.7%)⁵.
 - c. Cuyahoga County's **suicide rate** is 12.1, exceeding the national benchmark of 10.2 (per 100,000). In surveys, county residents report an average of 3.7 **poor mental health days** per month⁶. 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)⁷.
 - d. The number of **unintentional opioid deaths** in 2017 was high in Ohio overall (39.2 per 100,000) and in Cuyahoga County (37.8). In the city of Cleveland, the rate of unintentional opioid deaths was about almost twice as high (72.5) as in the county overall. The rate of unintentional opioid deaths in the city of Cleveland is five times that of the U.S. overall (14.5)⁸.
 - e. **Transportation** was mentioned by social service agency participants and community residents at separate focus groups as a concern which impacts access to jobs, healthcare, school and ability to socialize. In particular, community residents highlighted the lack of access to public transportation. One-

³ 2019 Cuyahoga County Community Health Needs Assessment. Cuyahoga County, Ohio. October 2019.

⁴ Cuyahoga County Board of Health (CCBH) using Vital Statistics provided by the Ohio Department of Health (ODH).

⁵ 2019 Cuyahoga County Community Health Needs Assessment. Cuyahoga County, Ohio. October 2019.

⁶ Suicide Deaths. The National Institute of Mental Health Information Resource Center. May 29, 2019.

<https://www.nimh.nih.gov/health/statistics/suicide.shtml>.

⁷ Homicide deaths. Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. Accessed May 28, 2019. <https://wisqars-viz.cdc.gov:8006/explore-data/home>.

⁸ Cuyahoga County Board of Health (CCBH) using data obtained from the Cuyahoga County Medical Examiner's Office.

fifth of all Cuyahoga County households located in a food desert do not have a vehicle⁹.

5. **Diseases of the circulatory system** (15.2%) and **diseases of the respiratory system** (9.6%) were the most common reasons Cuyahoga County residents were hospitalized in 2017. The most common ambulatory care sensitive (ACS) conditions for Cuyahoga County residents in 2017 were **chronic obstructive pulmonary disease** (3.2%), **congestive heart failure** (1.8%) and **diabetes** (1.7%)¹⁰.



Community Served by Hospitals

The hospital facilities that partnered with one another and with the two local public health departments to develop the 2019 Cuyahoga County CHNA recognized that a county-level definition of community would allow them to continue to comprehensively assess the health needs of their patients and the community in which their medical centers are located, while also identifying strengths on which to build additional community capacity. This shift also allows the health care systems to more readily collaborate with public health partners and other key stakeholders for both community health assessments and equity-grounded health improvement planning. This innovative, collaborative approach enables larger scale collective impact on previously intractable problems resulting in health inequities across the region. Lastly, each of the hospitals partnering on this CHNA had the majority of their patient discharges from Cuyahoga County.

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.

Priorities:

1. Eliminating structural racism*
2. Enhancing trust and trustworthiness across sectors, people and communities*
3. Addressing community conditions, such as reducing poverty and its effects
4. Enhancing mental health and reducing substance abuse 
5. Reducing chronic illness and its effects 



** Long-term, cross-cutting needs that are both stand-alone priorities and also undergird each of the other identified needs.*

⁹ Cuyahoga County Supermarket Assessment: 2018 Inventory Update. Accessed May 28, 2019. <https://www.countyplanning.us/projects/creating-healthy-communities/>.

¹⁰ Ohio Hospital Association. All Acute Care Hospitalizations Discharged in 2017 Primary Diagnostic Category.

Cross-Cutting Factors:

The Ohio SHIP contains strategies that are referred to as cross-cutting. This means that cross-cutting strategies have an impact on all selected priority areas. Certain priorities identified in the 2019 Joint Cuyahoga County CHNA also fit within the following cross-cutting areas:

1. Social determinants of health (Community Conditions) 
2. Equity (eliminating structural racism) 

Strategies to Address Health Needs

The Cuyahoga County Community Health Partners identified shared indicators for each of the five priority areas; developed an inventory of strategies underway by each state mandated partner and determined two aligned strategies involving all partners that are outlined in this report.

The strategies listed on the following pages delineate University Hospitals' specific strategies to address the five priority areas as well as the two aligned strategies involving all the Cuyahoga Community Health Partners. Collectively, these strategies are being implemented to achieve the anticipated county level outcomes.



STRATEGIES

University Hospitals Ahuja Medical Center

CHNA Priority: Chronic Disease Management and Prevention

Strategy 1:

- Community-based education, health screening and support groups to prevent and/or manage chronic diseases

Goal:

- Improve wellbeing of adults in Cuyahoga County via chronic disease prevention and management, particularly for diabetes and heart disease.

Objective:

- Educate and screen individuals in targeted locations to increase early detection of chronic diseases, promote prevention and/or improve treatment compliance, by December 2022.

Action Steps:

Years 1-3

- Offer health education talks, support groups and connection to resources to at least 5000 individuals. (Track the number of participants, type of events, percent of patients with improved health outcomes where feasible and number of referrals to primary care physicians where relevant.)
- Conduct 7,000 screenings at corporations, YMCA, schools, temples, churches, senior centers, low-income apartments, community health fairs and rehabilitation centers (Track the number of events, participants and positive screening results.)
- Host a Men' Health Fair.

* Anticipated measurable outcome(s): By December 2022

- Reduce (or maintain) the percent of adults age 20+ years who have ever been diagnosed with diabetes (baseline: 9.3% in 2016).
- Reduce (or maintain) the percent of adults age 20+ years who are obese in Cuyahoga County (baseline: 30.2% in 2016).
- Reduce (or maintain) the age-adjusted death rate due to coronary heart disease (baseline: 114.8 per 100,000 from 2015-2017)

Indicator(s) used to measure progress:

- Percent of adults age 20+ years who have ever been diagnosed with diabetes; also by race (Centers for Disease Control on the Healthy NEO website: <http://www.healthyneo.org/>)
- Percent of adults age 20+ years who are obese; also by race (Centers for Disease Control on the Healthy NEO website: <http://www.healthyneo.org/>)
- Age-adjusted death rate due to coronary heart disease; also by race (Centers for Disease Control on the Healthy NEO website: <http://www.healthyneo.org/>)
- Program evaluation form to include a question regarding perception of organizational trustworthiness as a community-engaged partner

Collaboration and Partnerships: Warrensville Heights Family YMCA, Warrensville Heights Civic & Senior Center, Orange Senior Center, Beachwood City Schools, Twinsburg City School District, Solon Community Center, Solon Civic Club, Shaker Place Apartments, Beachwood RH, LLC (UH Rehabilitation Hospital), Beachwood Chamber of Commerce, Solon Chamber of Commerce, Nardon Hills Chamber of Commerce, City of Beachwood, City of Warrensville Heights, City of Solon, Twinsburg Fire Department, University Heights Fire Department, Siemens Corporation, UH EMS Institute, Cleveland Marathon

** Outcomes are based on a variety of tactics occurring among Cuyahoga Community Health Partners to achieve the anticipated results at the county level.*

University Hospitals Ahuja Medical Center

CHNA Priority: Improve Community Conditions (Cross-cutting Factor)

Strategy 1:

- Strategic partnerships and programming to address social determinants of health

Goal:

- Increase access to resources for vulnerable populations including under-resourced individuals, youth and infants in particular in Cuyahoga County.

Objective:

- Implement programs and events to connect individuals with resource providers; reduce food insecurity; increase safety; and expose youth to careers in health care professions, by December 2022.

Action Steps:

Years 1-3

- Resources (track number of attendees and type of resources provided)
 - Host Breakfast with Santa resource fair in collaboration with Warrensville Heights Family YMCA.
- Food security (Track number of participants)
 - Partner with Sodexo to offer a free Summer Lunch Program for children 18 years of age and younger.
 - Provide healthy cooking classes to promote the importance of nutrition as a preventive measure and to remove barriers to trying new and/or different food options and recipes at the Women's Health Expo, wellness seminars and Family Health & Safety Days.
 - Offer nutrition classes to students at Warrensville Heights Middle School.
 - Offer nutrition classes in connection with diabetes and heart education and support groups; also the Fibromuscular Dysphasia support group.
- Safety (track number of participants)
 - Partner with schools and municipalities to provide Stop the Bleed training and toolkits to educate individuals on gun safety and injury prevention in "active-shooter" situations
- Youth workforce development (track number of participants)
 - Implement the Beachwood Medical Academy with Beachwood City Schools and Twinsburg City School Districts to expose youth to careers in healthcare professions.

Year 2

- Seek funding to reinstitute the Stop the Hunger Backpack Program to provide food for the weekend for under-resourced children
- Work with partners to identify strategies and resources specifically targeting social determinants of health impacting African American pregnant women. (A new Labor and Delivery unit is expected to open at UH Ahuja Medical Center in 2022.)

* **Anticipated measurable outcome(s):** By December 2022

- Maintain the downward trend of the percentage of Cuyahoga County children living below the poverty level (baseline: 26.9%, 2013-2017). 📊
- Maintain the downward trend of people in Cuyahoga County living below the poverty level (baseline: 18.3%, 2013-2017). 📊

Indicator(s) used to measure progress:

- Percent of Cuyahoga County children living below the poverty level; also by race (American Community Survey on the Healthy NEO website: <http://www.healthyneo.org/>) 📊
- Percent of people in Cuyahoga County living below the poverty level; also by race (American Community Survey on the Healthy NEO website: <http://www.healthyneo.org/>) 📊
- Food insecure rate: percent of Cuyahoga County population that experienced food insecurity at some point during the year (Feeding America on the Healthy NEO website: <http://www.healthyneo.org/>)
- Program evaluation form to include a question regarding perception of organizational trustworthiness as a community-engaged partner

Collaboration and Partnerships: Warrensville Heights Family YMCA; communities of Nordonia Hills, Warrensville Heights, Highland Hills, Solon, Orange, Mayfield Heights, Twinsburg, Chagrin Falls, Cleveland Heights, University Heights, North Randall, Shaker Heights, Highland Hills, Beachwood, Pepper Pike, Lyndhurst, Richmond Heights, Highland Heights; Sodexo; Amazon Corporation; NSL Analytical Corporation; and area business and community leaders

** Outcomes are based on a variety of tactics occurring among Cuyahoga Community Health Partners to achieve the anticipated results at the county level.*

University Hospitals Ahuja Medical Center

CHNA Priority: Mental Health and Addiction

Strategy 1:

- Community-based education to promote positive mental health

Goal:

- Arrest upward trend of overall suicide deaths and drug-related overdose deaths in Cuyahoga County.

Objectives: By December 2022

- Provide a variety of classes to teach individuals healthy coping mechanisms to manage stress.
- Provide a series of physician talks and expos to connect individuals and caregivers with best practices and resources to reduce illegal drug dependency, use and misuse of opioids.

Action Steps:

Years 1-3

- Work with UH Connor Integrative Health Network to offer community-based mindfulness classes, massage and acupuncture sessions, and wellness talks (Track number of participants and events.)
- Host two Family Health & Safety Days. (Track number of participants, screenings, and positive screening results.)
- Host three targeted health expos focused on Women's Health, Men's Health and Healthy Living. (Track number of participants, screenings and positive screening results.)
- Work with UH Pain Management Institute to provide physician talks on opioids. (Track number of participants.)
- Provide music therapy at wellness events at UH Ahuja Medical Center and at the Warrensville Heights Civic & Senior Center. (Track number of participants.)
- Provide a total of 40 classes or physician talks for community members.

* Anticipated measurable outcome(s):

- Reduce the age-adjusted death rate in Cuyahoga County due to suicide (baseline: 12.3 per 100,000 population 2015-2107).
- Reduce the unintentional opioid-related death rate per 100,000 population in Cuyahoga County (baseline: 37.8 in Cuyahoga County; 72.5 in Cleveland in 2017).

Indicator(s) used to measure progress:

- Age-adjusted death rate due to suicide in Cuyahoga County, also by race (Centers for Disease Control, Healthy NEO)
- Unintentional opioid-related deaths per 100,000 in Cuyahoga County, also by race (Medical Examiner's Office, Cuyahoga County Board of Health, CCBH/Medical Examiner's Office in 2019 CHNA)

- Program evaluation form to include a question regarding perception of organizational trustworthiness as a community-engaged partner

Collaboration and Partnerships: Warrensville Heights Family YMCA, Warrensville Heights Civic & Senior Center, Orange Senior Center, Beachwood City Schools, Twinsburg City School District, Solon Community Center, Solon Civic Club, Shaker Place Apartments, Beachwood RH, LLC (UH Rehabilitation Hospital), Beachwood Chamber of Commerce, Solon Chamber of Commerce, Nordonia Hills Chamber of Commerce, City of Beachwood, City of Warrensville Heights, City of Solon, Twinsburg Fire Department, University Heights Fire Department, Siemens Corporation, UH EMS Institute, Cleveland Marathon

** Outcomes are based on a variety of tactics occurring among Cuyahoga Community Health Partners to achieve the anticipated results at the county level.*



University Hospitals Rehabilitation Hospital

A Joint Venture with Kindred Healthcare

STRATEGIES

Beachwood RH, LLC (UH Rehabilitation Hospital)

CHNA Priority: Chronic Disease Management and Prevention

Strategy 1:

- Community-based education and health screenings to prevent and/or manage chronic diseases

Goal:

- Improve wellbeing of adults in Cuyahoga County via chronic disease prevention and management, particularly stroke victims.

Objectives: By December 2022


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

Action Steps:


Years 1-3

- Continue to host a monthly stroke support group; featuring different wellness talks each month. (Track number of participants and number of events.)
- Provide healthy eating/cooking classes quarterly. (Track number of participants.)
- Participate in Family Health & Safety Days through UH Medical Centers and other health-related events to provide health education and screenings: blood pressure, grip and balance in particular. (Track number of participants, screenings, and positive screening results.)
- Increase publicity for UH Rehabilitation Hospital's community classes on the website, through the UH Age Well-Be Well newsletter and other appropriate media vehicles. (Track media outlets.)
- Host a stroke awareness event for World Stroke Day in October. (Track number of participants.)

* Anticipated measurable outcome(s):

- Reduce (or maintain) the age-adjusted death rate in Cuyahoga County due to coronary heart disease (baseline: 114.8 per 100,000 from 2015-2017). 

Indicator(s) used to measure progress:

- Reduced number of readmissions at UH Rehabilitation Hospital due to stroke; also by race (Internal UH data)
- Age-adjusted death rate due to coronary heart disease in Cuyahoga County; also by race (Centers for Disease Control on the Healthy NEO website: <http://www.healthyneo.org/>) 
- Program evaluation form to include a question regarding perception of organizational trustworthiness as a community-engaged partner

Collaboration and Partnerships: Partnership with UH Medical Centers, UH physicians and physical therapists

** Outcomes are based on a variety of tactics occurring among Cuyahoga Community Health Partners to achieve the anticipated results at the county level.*



University Hospitals

Bedford Medical Center

Richmond Medical Center

Campuses of UH Regional Hospitals

S T R A T E G I E S

University Hospitals Bedford & Richmond Medical Centers

CHNA Priority: Chronic Disease Management and Prevention

Strategy 1:

- Community-based education and health screenings to prevent and/or manage chronic diseases

Goal:

- Improve wellbeing of adults in Cuyahoga County via chronic disease prevention and management; reduce incidence of diabetes and coronary heart disease and mortality.

Objectives: By December 2022

- Increase the number of people in the community screened for early detection of chronic diseases (target: 200 at each hospital annually).
- Increase awareness and education of chronic disease prevention and management (target 250 individuals at each hospital annually).

Action Steps:


Year 1

- Continue to host Family Health & Safety Days and participate in health fairs throughout the city, emphasis on addressing diabetes and heart disease. (Track number of participants.)
- Provide free screenings at various venues in the community to increase early detection of chronic diseases including the following screenings: calcium scoring, lower vascular, glucose, etc., emphasis on reaching populations with barriers to access to health care. (Track number of participants, screenings and positive screening results.)
- Provide access to healthcare professionals via physician talks, including topics such as respiratory, diabetes and heart health. (Track number of participants.)
- Provide wellness education materials to patients upon discharge. (Track number of encounters.)
- Re-brand the diabetes support group as a pilot weight management program to increase participation. (Track number of participants.)

Years 2-3

- Continue Year 1 activities.
- Identify a curriculum and venues to provide workshops on the risks and dangers of vaping.

* Anticipated measurable outcome(s): By December, 2022

- Reduce (or maintain) the percent of Cuyahoga County adults age 20+years who have ever been diagnosed with diabetes (baseline: is 9.3% in 2016). 
- Reduce (or maintain) the percent of Cuyahoga County adults age 20+ years who are obese in Cuyahoga County, also by race (baseline 30.2% in 2016).

- Reduce (or maintain) the age-adjusted death rate due to coronary heart disease in Cuyahoga County (baseline: 114.8 per 100,000 from 2015-2017). 🇺🇸

Indicator(s) used to measure progress:

- Percent of Cuyahoga County adults age 20+ years who have ever been diagnosed with diabetes, also by race (Centers for Disease Control on the Healthy NEO website: <http://www.healthyneo.org/>) 🇺🇸
- Percent of Cuyahoga County adults age 20+ years who are obese, also by race (Centers for Disease Control on the Healthy NEO website: <http://www.healthyneo.org/>)
- Age-adjusted death rate due to coronary heart disease in Cuyahoga County; also by race (Centers for Disease Control on the Healthy NEO website: <http://www.healthyneo.org/>) 🇺🇸
- Program evaluation form to include a question regarding perception of organizational trustworthiness as a community-engaged partner

Collaboration and Partnerships: Health professionals: dietitians, physicians, nurse practitioners, UH 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 institutions and local schools

** Outcomes are based on a variety of tactics occurring among Cuyahoga Community Health Partners to achieve the anticipated results at the county level.*

University Hospitals Bedford and Richmond Medical Centers

CHNA Priority: Improve Community Conditions (Cross-cutting Factor)

Strategy 1:

- Raise awareness about hospital utilization options and financial assistance available for medical care.

Goal:

- Increase access to care by removing perceived barriers due to financial insecurity.

Objective: By December 2022:

- Discuss and distribute information to at least 200 community members at each hospital regarding appropriate options for hospital utilization and financial counseling services available.

Action Steps:

Years 1-3

- Provide customized print materials describing financial counseling services available to eligible individuals (Track number distributed)
- Educate community members regarding the choice of appropriate health care option (physician visit, emergency department, urgent care, etc.) when needed to prevent worsening conditions and need for higher cost services. (Track number of encounters.)

*** Anticipated measurable outcome(s):**

- Maintain the downward trend of people in Cuyahoga County living below the poverty level (baseline: 18.3%, 2013-2017).

Indicator(s) used to measure progress:

- Percent of people in Cuyahoga County living below the poverty level, also by race (American Community Survey on the Healthy NEO website: <http://www.healthyneo.org/>)
- Percent of Cuyahoga County households that are above the asset limited, income constrained, employed (ALICE) threshold: 53.3% in 2016 (United for ALICE on the Healthy NEO website: <http://www.healthyneo.org/>)
- Program evaluation form to include a question regarding perception of organizational trustworthiness as a community-engaged partner


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

** Outcomes are based on a variety of tactics occurring among Cuyahoga Community Health Partners to achieve the anticipated results at the county level.*




STRATEGIES

University Hospitals Cleveland Medical Center
Harrington Heart and Vascular Institute
CHNA Priority: Chronic Disease Management and Prevention 🇺🇸
Strategy 1: <ul style="list-style-type: none"> Community-based education and health screenings
Goal: <ul style="list-style-type: none"> Reduce the incidence of cardiovascular disease among Cuyahoga County residents.
Objectives: By December 2022: <ul style="list-style-type: none"> Increase calcium score screening. Increase reach with under-resourced populations. Increase knowledge of patients and community members regarding prevention of heart disease and/or management of chronic disease for diagnosed individuals.
Action Steps: <p>Years 1-3</p> <ul style="list-style-type: none"> Annually host 50 physician-lead health talks and/or screening events in strategic locations to reach under-resourced populations. (Track number of events.) Annually screen 1,000 or more individuals for cardiovascular disease and provide information about their results. (Track number of participants, screenings, and positive screening results.) Annually educate 2,000 or more individuals regarding vascular disease, cardiovascular risk factors and lifestyle, medication adherence, CPR, AED and smoking/vaping cessation/education. (Track number of participants.)
* Anticipated measurable outcome(s): <ul style="list-style-type: none"> Reduce (or maintain) the age-adjusted death rate due to coronary heart disease in Cuyahoga County (baseline: 114.8 per 100,000 from 2015-2017). 🇺🇸 Reduce (or maintain) the percent of adults age 20+ years who are obese in Cuyahoga County (baseline 30.2% in 2016).
Indicator(s) used to measure progress: <ul style="list-style-type: none"> Percent of Cuyahoga County adults age 20+ years who are obese, also by race (Centers for Disease Control on the Healthy NEO website: http://www.healthyneo.org/) Age-adjusted death rate due to coronary heart disease in Cuyahoga County, also by race (Centers for Disease Control on the Healthy NEO website: http://www.healthyneo.org/) 🇺🇸 Program evaluation form to include a question regarding perception of organizational trustworthiness as a community-engaged partner
Collaboration and Partnerships: American Heart Association, Breakthrough Schools, Cuyahoga County Metropolitan Housing Authority Hunger Network, Ursuline College, City of Cleveland


University Hospitals Cleveland Medical Center
UH Seidman Cancer Center
CHNA Priority: Chronic Disease Management and Prevention 
Strategy 2: Targeted screening and education among high-risk populations
Goal: <ul style="list-style-type: none"> Decrease late-stage diagnoses outcomes in two cancers with evidence-based screening recommendations in target high-risk subpopulations by December 2022.
Objectives: <ul style="list-style-type: none"> Provide education and screenings to 750 participants. Host and/or participate in 12 educational screening events.
Action Steps: <p>Year 1</p> <ul style="list-style-type: none"> Continue to provide select cancer screenings and education in current catchment area (Cleveland) with proper education and awareness messaging. (Track number of participants, screenings and positive screening results.) <p>Years 2-3</p> <ul style="list-style-type: none"> Expand catchment area to adjacent counties to increase outreach efforts. Coordinate efforts with additional UH sites to broaden reach.
* Anticipated measurable outcome(s): <ul style="list-style-type: none"> Decrease/maintain the downward trend of age-adjusted death rate due to breast cancer in Cuyahoga County (baseline: 25.2 deaths per 100,000, 2012-2016). Decrease/maintain current flat trend of age-adjusted death rate due to colorectal cancer in Cuyahoga County (baseline: 15.2 deaths per 100,000 females, 2012-2016).
Indicator(s) used to measure progress: <ul style="list-style-type: none"> Decrease (or maintain) the age-adjusted death rate due to breast cancer in Cuyahoga County (National Cancer Institute on the Healthy NEO website: http://www.healthyneo.org/) Decrease (or maintain current flat trend) the age-adjusted death rate due to colorectal cancer in Cuyahoga County National Cancer Institute on the Healthy NEO website: http://www.healthyneo.org/) Improved early-stage cancer detection among under-resourced community members in Cuyahoga County (Source for Data: UH)
Collaboration and Partnerships: Cleveland Department of Public Health, City of Cleveland, Cleveland Clinic Foundation, The MetroHealth System

** Outcomes are based on a variety of tactics occurring among Cuyahoga Community Health Partners to achieve the anticipated results at the county level.*

** Outcomes are based on a variety of tactics occurring in the Case Comprehensive Cancer Center to achieve the anticipated results at the county level.*

University Hospitals Cleveland Medical Center
UH Seidman Cancer Center
CHNA Priority: Chronic Disease Management and Prevention 
Strategy 3: Decrease barriers to cancer screening and treatment
<p>Goals:</p> <ul style="list-style-type: none"> • Increase collaboration with federally qualified health centers and other partners serving under-resourced communities to increase access to specialty care. • Address transportation and navigation barriers by providing services in the community via a mobile health unit.
<p>Objective:</p> <ul style="list-style-type: none"> • Improve accessibility of cancer screening and education in targeted high-risk populations by December 2022.
<p>Action Steps:</p> <p>Year 1</p> <ul style="list-style-type: none"> • Secure and formulate outreach plan for wellness van (mammography, FIT test and navigation). <p>Year 2</p> <ul style="list-style-type: none"> • Collaborate with at least one community partner to provide relevant screening and subsequent navigation beginning in Cuyahoga County. <p>Year 3</p> <ul style="list-style-type: none"> • Increase collaboration with community partner(s) to at least two with one being a federally qualified health center (FQHC).
<p>* Anticipated measurable outcome(s):</p> <ul style="list-style-type: none"> • Decrease/maintain the downward trend of age-adjusted death rate due to breast cancer in Cuyahoga County (baseline: 25.2 deaths per 100,000, 2012-2016). • Decrease/maintain current flat trend of age-adjusted death rate due to colorectal cancer in Cuyahoga County (baseline: 15.2 deaths per 100,000 females, 2012-2016).
<p>Indicator(s) used to measure progress:</p> <ul style="list-style-type: none"> • Decreased (or maintained) age-adjusted death rate due to breast cancer in Cuyahoga County, also by race (National Cancer Institute on the Healthy NEO website: http://www.healthyneo.org/) • Decreased (or maintained current flat trend) age-adjusted death rate due to colorectal cancer in Cuyahoga County, also by race (National Cancer Institute on the Healthy NEO website: http://www.healthyneo.org/) • Improved early-stage cancer detection among under-resourced community members in Cuyahoga County, also by race (UH data)
<p>Collaboration and Partnerships: Cleveland Department of Public Health, City of Cleveland, Cleveland Clinic Foundation, The MetroHealth System, FQHC's (to be defined)</p>

* Outcomes are based on a variety of tactics occurring in the Case Comprehensive Cancer Center to achieve the anticipated results at the county level.

University Hospitals Cleveland Medical Center
Harrington Heart and Vascular Institute
CHNA Priority: Improve Community Conditions (Cross-cutting Factor) 
Strategy 1: Safety training
<p>Goals:</p> <ul style="list-style-type: none"> • Increase the survival rate of victims of gun violence at schools. • Increase the survival rate of individuals experiencing cardiac arrest.
<p>Objectives: By December 2022</p> <ul style="list-style-type: none"> • Increase the number of students who are prepared to respond in the event of traumatic injuries at school. • Increase the number of individuals who know Cardiopulmonary Resuscitation (CPR) and how to use an Automated External Defibrillator (AED) machine.
<p>Action Steps:</p> <p>Year 1</p> <ul style="list-style-type: none"> • Continue to train community members and first responders in various locations throughout the county on CPR and AED as part of the Cardiac Free Zone initiative • Train students in local schools in Cuyahoga County through the Stop the Bleed program with a target of 5,000 trained in CPR/AED/Stop the Bleed. (Track number trained.) • Explore youth violence prevention programs and activities, potential partners and resources to enhance safety programs in Cuyahoga County. <p>Years 2-3</p> <ul style="list-style-type: none"> • Continue Year 1 activities. • Pending Year 1 results, integrate violence prevention components in schools, similar to “See Something, Say Something” initiatives. • Host a Survivor’s’ dinner. • Offer workshops on the dangers of vaping.
<p>* Anticipated measurable outcome(s):</p> <ul style="list-style-type: none"> • Increase in the number of survivors of gun-violence by 1%. • Increase in the number of survivors of cardiac arrest by 1%.
<p>Indicator(s) used to measure progress:</p> <ul style="list-style-type: none"> • Survival rates for gun-related injuries; also by race (Internal UH Trauma Department data) • Program evaluation form to include a question regarding perception of organizational trustworthiness as a community-engaged partner
<p>Collaboration and Partnerships: Local first responder departments, UH EMS Institute, Case Western Reserve University, local school districts and public safety agencies, UH Medical Centers</p>

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University Hospitals Cleveland Medical Center

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

CHNA Priority: Improve Community Conditions (Cross-cutting Factor)

Strategy 2:

- Co-locate programs and services within a community-based medical center in an under-resourced neighborhood.

Goal:

- Improve overall health outcomes of patients by integrating resources to address social determinants of health.

Objectives: By December 2022



- Reduce food insecurity and prevent chronic disease and/or disease progression for under-resourced patients.
- Increase access to care for African-American men.
- Assist patients with navigating systems of care to attain necessary social services.
- Provide community space for job training, wellness classes, support groups, etc.

Action Steps:

Years 1-3

- Screen patients for social determinants of health and provide or refer them to appropriate social service providers (Track number screened and referred)
- Partner with Sodexo to provide 35 pounds on average (per person/per household) of shelf food and fresh produce through the Food for Life Market; includes nutrition coaching and counseling, and pre and post screening for blood pressure and A1C levels. (Track number served, amount of food distributed and screening results.)
- Partner with Dave's Markets to offer cooking classes in the community. (Track number of participants.)
- Establish strategic partnerships and host events targeting Men's Health. (Track number of participants and events.)
- Partner with MedWorks to host 3 "pop-up" medical clinics, open to the public. (Track number served and relevant outcomes.)
- Provide extended hours of operation and a walk-in clinic to increase access to care.
- Partner with AmeriCorp to dedicate two community health workers to better connect individuals with resources and to offer community-based wellness classes at, or near, the UH Otis Moss, Jr. Center. (Track number of encounters and/or classes.)

* Anticipated measurable outcome(s):


- Maintain the downward trend of the percentage of Cuyahoga County children living below the poverty level (baseline: 26.9%, 2013-2017). 
- Maintain the downward trend of people in Cuyahoga County living below the poverty level (baseline: 18.3%, 2013-2017). 
- Food insecure rate: percent of Cuyahoga County population that experienced food insecurity at some point during the year (baseline: 18.4%. 2013-2017).

Indicator(s) used to measure progress:

- Percent of Cuyahoga County children living below the poverty level, also by race (American Community Survey on the Healthy NEO website: <http://www.healthyneo.org/>)
- Percent of people in Cuyahoga County living below the poverty level, also by race (American Community Survey on the Healthy NEO website: <http://www.healthyneo.org/>)
- Food insecure rate: percent of Cuyahoga County population that experienced food insecurity at some point during the year (Feeding America on the Healthy NEO website: <http://www.healthyneo.org/>)
- Health outcomes from participants, i.e. weight loss, reduction of A1C, blood pressure, also by race
- Program evaluation form to include a question regarding perception of organizational trustworthiness as a community-engaged partner

Collaboration and Partnerships: Sodexo, Olivet Institutional Baptist Church

** Outcomes are based on a variety of tactics occurring among Cuyahoga Community Health Partners to achieve the anticipated results at the county level.*

University Hospitals Cleveland Medical Center
Adult Trauma Program, Violence Interrupters Program
CHNA Priority: Improve Community Conditions (Cross-cutting Factor) 
Strategy 3: <ul style="list-style-type: none"> Hospital-based intervention to interrupt gun-related violence and retaliation
Goal: <ul style="list-style-type: none"> Reduce gun-related violence, retaliation and recidivism.
Objective: <ul style="list-style-type: none"> Following violent incidents, connect all eligible patients to mediation, conflict resolution and case management services while hospitalized and referral to necessary social services upon discharge.
Action Steps: <p>Year 1</p> <ul style="list-style-type: none"> Continue to partner with Peacemakers Alliance to provide outreach workers to intervene in gun-related incidents in the hospital. Continue to engage the victim’s family and community members while the patient is hospitalized to reduce the potential of retaliatory violence. Continue to refer victims to outpatient community services, addressing social determinants of health, such as education and job placement at the time of discharge. (Track number served and number of referrals.) <p>Years 2-3</p> <ul style="list-style-type: none"> Continue Year 1 activities. Seek additional funding to make the program more sustainable and to create opportunities for expansion of the target population to include victims living outside Cleveland and beyond the 16 to 25 age group.
<p>* Anticipated measurable outcome(s): By December 2022</p> <ul style="list-style-type: none"> Maintain the downward trend of the violent crime rate in Cuyahoga County (baseline: 500.5 per 100,000). Reduce (or maintain) homicide rate of 14.2 per 100,000 population in Cuyahoga County and 28.3 per 100,000 population in Cleveland, 2017). Reduce the rate of gun-related deaths in Cuyahoga County (baseline: 18.3 per 100,000 population for Cuyahoga County and 29.8 per 100,000 for Cleveland in 2016).
Indicator(s) used to measure progress: <ul style="list-style-type: none"> Violent crime rate for Cuyahoga County, also by race (Ohio Department of Public Safety, Office of Criminal Justice Services on the Healthy NEO website: http://www.healthyneo.org/) Homicide rates for Cuyahoga County and Cleveland, also by race (CCBH Vital Stats in the 2019 CHNA)

- Rate of gun-related deaths, also by race (Cuyahoga County Board of Health Vital Statistics, Ohio Department of Health in the 2019 CHNA)
- Program evaluation form to include a question regarding perception of organizational trustworthiness as a community-engaged partner

Collaboration and Partnerships: Cleveland City Council, United Way, Peacemakers Alliance, Northern Ohio Trauma System (NOTS)

** Outcomes are based on a variety of tactics occurring among Cuyahoga Community Health Partners to achieve the anticipated results at the county level.*

University Hospitals Cleveland Medical Center

Pain Management Institute

CHNA Priority: Mental Health and Addiction

Strategy 1:

- Community-based education and strategic partnerships

Goal:

- Reduce the number of overdose deaths in Cuyahoga County.

Objectives: By December 2022

- Increase knowledge about the risks and resources available to prevent or treat substance addiction.
- Raise awareness about proper prescription drug disposal
- Prepare the future workforce for careers in behavioral health science.

Action Steps:


Year 1

- Develop a community-based approach to increase reach and understanding of substance use/misuse among youth and adults in Cuyahoga County. This includes the development of strategic partnerships to expose youth to careers in behavioral health sciences.
- Continue to participate in the NEO Hospital Opioid Consortium to enhance the expansive clinical practice available at University Hospitals to address pain management and substance use/abuse.
- Partner with PSI to develop a curriculum for a series of educational videos to raise awareness about the dangers of drug use/misuse for youth and parents (Document the number/type of videos).
- Continue to participate in Family Health and Safety and other appropriate venues to provide approximately 6,000 medication disposal kits and raise awareness regarding medication drop-off locations. (Track number distributed.)
- Publicize free, guided meditation videos developed by the UH Connor Integrative Health Network.

Years 2-3

- Identify appropriate venues and clinicians/speakers to educate youth and adults regarding substance use/abuse in schools, youth health events and other appropriate venues.
- Conduct health/physician talks at schools, conferences, community settings using the video series and/or to raise awareness about careers in behavioral health. (Track number of participants.)

* Anticipated measurable outcome(s):

- Reduce the unintentional opioid-related death rate per 100,000 population in Cuyahoga County (baseline: 37.8 in Cuyahoga County, 72.5 in Cleveland in 2017) 

Indicators used to measure progress:


- Unintentional opioid-related deaths per 100,000 in Cuyahoga County, also by race (Medical Examiner's Office, Cuyahoga County Board of Health, CCBH/Medical Examiner's Office in 2019 CHNA) 📌
- Number of deaths due to unintentional drug overdoses in Cuyahoga County, 44.1 per 100,000 population, 2015-2016 (Cuyahoga County Board of Health, Vital Statistics in the 2019 CHNA) 📌
- Program evaluation form to include a question regarding perception of organizational trustworthiness as a community-engaged partner

Collaboration and Partnerships: PSI, NEO Hospital Opioid Consortium, UH Medical Centers, local schools

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University Hospitals Cleveland Medical Center

Community Impact, Equity, Diversity and Inclusion (CEDI) UH Health Scholars Program

CHNA Priority: Eliminating Structural Racism (Cross-cutting Factor) 

Strategy 1:

- Job pipeline program for minoritized* secondary school students interested in becoming physicians

Goal:

- Increase the number of physicians from minoritized populations to create pathways for a more diverse and inclusive healthcare workforce.

Objective:

- Equip 45 students with the necessary post-secondary education/training to prepare them for careers as physicians.

Action Steps:

Years 1-3

- Offer workshops, hands-on activities, shadowing etc. throughout the year to build and develop social/emotional learning, executive functioning skills, and an academic profile for students.

Anticipated measurable outcome(s): By December 2022

- The majority of students will maintain good grades and test scores.
- The majority of students will qualify for admissions to an accredited undergraduate institution.
- The majority of students will have absence and attendance records better than their district average.
- The majority of students will have a discipline record better than their district average.
- 45 students will complete the Health Scholars program annually (across multiple cohorts).
- 30 students will enroll in an accredited pre-professional four-year degree program that prepares students for medical school.

Indicator(s) used to measure progress:

- Health Scholars self-assessments
- School grades, attendance, disciplinary records and standardized test scores
- Completion of necessary high school classes needed to enter a pre-professional/pre-med college program
- Acceptance into an accredited pre-professional four-year degree program which prepares students for medical school

Collaboration and Partnerships: Local nonprofits and businesses (College Now, New Bridge, Dick Blake, etc.), schools, senior centers, low income apartments, Chamber of Commerce

* 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



STRATEGIES

University Hospitals Parma Medical Center

CHNA Priority: Chronic Disease Management and Prevention

Strategy 1:

- Community-based education and health screenings to prevent and/or manage chronic diseases, particularly for diabetes and heart disease

Goal:

- Improve wellbeing of adults in Cuyahoga County via chronic disease prevention and management; reduce incidence of diabetes and coronary heart disease and mortality.

Objectives: By December 2022



- Detect early signs of chronic diseases in an effort to prevent or mitigate disease progression (target: 5,000 screens annually, at least 200 events annually).
- Increase awareness and education of chronic disease prevention and management to improve health literacy and health outcomes (target: 1,000 annually).

Action Steps:


Years 1-3

- Conduct community-based events that offer screenings, health-related publications and handouts. (Track number of participants, screenings, and positive screening results.)
- Provide community-based programming to improve behavioral lifestyle choices. (Track number of participants and relevant outcomes.)
- Offer structured exercise programs at the Health Education Center. (Track number of participants and relevant outcomes.)
- Mail educational materials to households. (Track number of mailings.)
- Provide medical and clinical professionals to speak at events. (Track number of events and participants.)

* Anticipated measurable outcomes:

- Reduce (or maintain) the percent of Cuyahoga County adults age 20+ years who have ever been diagnosed with diabetes (baseline: 9.3% in 2016). 
- Reduce (or maintain) the percent of Cuyahoga County adults age 20+ years who are obese in Cuyahoga County (30.2% in 2016).
- Reduce (or maintain) the age-adjusted death rate due to coronary heart disease in Cuyahoga County (baseline: 114.8 per 100,000 from 2015-2017). 

Indicator(s) used to measure progress:

- Percent of Cuyahoga County adults age 20+ years who have ever been diagnosed with Diabetes, also by race (Centers for Disease Control on the Healthy NEO website: <http://www.healthyneo.org/>) 
- Percent of Cuyahoga County adults age 20+ years who are obese, also by race (Centers for Disease Control on the Healthy NEO website: <http://www.healthyneo.org/>)

- Age-adjusted death rate due to coronary heart disease in Cuyahoga County, also by race (Centers for Disease Control on the Healthy NEO website: <http://www.healthyneo.org/>)
- Program evaluation form to include a question regarding perception of organizational trustworthiness as a community-engaged partner

Collaboration and Partnerships: Senior centers in UH Parma Medical Center service areas, community health fairs, Alzheimer’s Association, CBS Connects (Parma City School Districts), Parkinson’s Foundation, North Royalton City Schools, The Arthritis Foundation, Parma City School District; Parma Area Family Collaborative, Padua High School, St. Albert the Great School, Brecksville-Broadview Heights City School District, North Royalton YMCA, YMCA of Greater Cleveland, American Heart Association, Parma Branch – Cuyahoga County Public Library, West Creek Conservancy, cities of Parma, North Royalton, Parma Heights, Seven Hills, Brooklyn, Brooklyn Heights and Broadview Heights

** Outcomes are based on a variety of tactics occurring among Cuyahoga Community Health Partners to achieve the anticipated results at the county level.*

University Hospitals Parma Medical Centers

CHNA Priority: Improve Community Conditions (Cross-cutting Factor)

Strategy 1:

- Healthy food access

Goal:

- Reduce food insecurity for under-resourced individuals.

Objective:


- By December 2022, increase access to healthy meals by providing 1) home-delivered meals to senior citizens in partnership with Meals on Wheels, and 2) lunch to children while visiting UH Parma Medical Center.

Action Steps:


Years 1-3

- Continue to provide at least 1,500 meals annually to residents in the cities of Seven Hills and Parma Heights with Meals on Wheels, in collaboration with senior centers in those communities. (Track number of meals provided.)
- Continue to provide at least 500 meals to children visiting the hospital through the Youth Summer Lunch Program in partnership with Sodexo, a food management company. (Track number of meals provided and children served.)

* Anticipated measurable outcomes:

- Maintain the downward trend of people in Cuyahoga County living below the poverty level (baseline: 18.3%, 2013-2017). 
- Reduce (or maintain) the percent of Cuyahoga County population that experienced food insecurity at some point during the year (baseline: 18.4%, 2013-2017).

Indicator(s) used to measure progress:

- Percent of people in Cuyahoga County living below the poverty level, also by race (American Community Survey on the Healthy NEO website: <http://www.healthyneo.org/>) 
- Food insecure rate: percent of Cuyahoga County population that experienced food insecurity at some point during the year (Feeding America on the Healthy NEO website: <http://www.healthyneo.org/>)
- Program evaluation form to include a question regarding perception of organizational trustworthiness as a community-engaged partner

Collaboration and Partnerships: Parma Area Collaborative, local food pantries, Sodexo, cities of Seven Hills, Parma Heights, UH Rainbow Babies & Children's Hospital

** Outcomes are based on a variety of tactics occurring among Cuyahoga Community Health Partners to achieve the anticipated results at the county level.*



STRATEGIES

University Hospitals Rainbow Babies & Children's Hospital

CHNA Priority: Improve Community Conditions (Cross-cutting Factor)

Strategy 1:

- Mobile dental clinic

Goals:

- Increase access to dental care for children ages 3 to 12 years in underserved populations that lack a regular sources of preventative dental care.
- Prevent early tooth decay and disease.

Objectives: By December 2022

- Reach at least 2,000 underserved children each year, throughout a 20-county area to provide routine dental screenings, cleanings and preventative care.
- Reduce the number of children with UH Emergency Department visits due to dental issues (Target: < 5 patients per week).

Action Steps:

Years 1-3

- Continue to provide routine dental screenings and cleanings at schools, Head Starts, public health agencies, etc. (Track number served and type of service.)
- Continue to provide preventive care, sealants, fluoride treatments, treatment of dental caries; offer treatment options include filling cavities, extractions, pulp therapy and placing crowns.
- Treat at least 93% of children served on the Care Mobile instead of referring out.

Anticipated measurable outcome(s):

- Decreased percentage of children with UH Emergency Department visits due to dental issues (Internal UH data)

Indicator(s) used to measure progress:

- Percent of UH Emergency Department visits due to dental issues (UH data and HCNO survey)
- Other indicators (pending data availability):
 - Percent of Cuyahoga County children who saw a dentist in the past year (HCNO survey)
 - Percent of Cuyahoga County children who did not receive necessary dental care (HCNO survey)

Collaboration and Partnerships: Ronald McDonald House Charities of Northeastern Ohio, Inc., Case Western Reserve University School of Dental Medicine; school districts, DDC Clinic - Center for Special Needs Children), public health departments; and residential treatment facilities throughout Northeast Ohio

University Hospitals Rainbow Babies & Children's Hospital

CHNA Priority: Improve Community Conditions/Eliminating Structural Racism (Cross-cutting Factors) 🇺🇸

Strategy 2:

- Nutrition programming to address food insecurity

Goal:

- Identify and address food insecurity and establish healthy eating habits for children (families).

Objectives: By December 2022

- Increase the number of patients screened for food insecurity.
- Implement programs to educate families on proper nutrition and healthy recipes.
- Provide healthy meals to children in the summer and on weekends.
- Reduce racial disparities regarding food insecurity.

Action Steps:

Years 1-3

- Ongoing staff training about unconscious bias and trauma informed care to aid in providing culturally competent community-based programming (and maintain high quality clinical care)
- Offer 6,300 meals to children through the USDA Summer Lunch Program each year (Track number of meals provided, children served.)
- Screen for food insecurity and assist families in obtaining necessary resources. (Track number screened and referrals.)
- Provide weekly cooking demonstrations for at least 50 families through the Healthy Harvest program each year; families are given the ingredients for the recipes to take home. (Track number of participants.)
- Host grocery store tours and cooking classes in partnership with Dave's Markets each year (Track number of participants)
- Provide weekend snacks for 450 children through the "Back Pack" program each year. (Track number of snacks provided, children served.)

* Anticipated measurable outcome(s):

- Maintain the downward trend of the percentage of Cuyahoga County children living below the poverty level (baseline: 26.9%, 2013-2017). 🇺🇸
- Maintain the downward trend of people in Cuyahoga County living below the poverty level (baseline: 18.3%, 2013-2017). 🇺🇸
- Reduce (or maintain) the percent of Cuyahoga County population that experienced food insecurity at some point during the year (baseline: 18.4%. 2013-2017).

Indicator(s) used to measure progress:

- Percent of Cuyahoga County children living below the poverty level, also by race (American Community Survey on the Healthy NEO website: <http://www.healthyneo.org/>)
- Percent of people in Cuyahoga County living below the poverty level, also by race (American Community Survey on the Healthy NEO website: <http://www.healthyneo.org/>)
- Food insecure rate: percent of Cuyahoga County population that experienced food insecurity at some point during the year (Feeding America on the Healthy NEO website: <http://www.healthyneo.org/>)

Collaboration and Partnerships: Dave's Markets, Local Matters, MidTown Cleveland Inc., Sodexo, Green City Growers, Greater Cleveland Food Bank, Ohio Department of Education

** Outcomes are based on a variety of tactics occurring among Cuyahoga Community Health Partners to achieve the anticipated results at the county level.*

University Hospitals Rainbow Babies & Children's Hospital

CHNA Priority: Improve Community Conditions/Eliminating Structural Racism (Cross-cutting Factors)

Strategy 3: Centering Pregnancy

Goal:

Improve birth outcomes through education, outreach, and coordination of health care and social services for pregnant women.

Objectives: By December 2022



- Decrease the number of infant deaths; decrease racial disparities.
- Decrease pre-term deliveries and low birth weight infants.
- Increase breastfeeding.

Action Steps:



Years 1-3

- Ongoing staff training about unconscious bias and trauma informed care to aid in providing culturally competent community-based programming (and maintain high quality clinical care).
- Continue to enroll women into the Centering Pregnancy program (target: 500 annually, 75% appointment compliance). (Track number enrolled and relevant outcomes.)
- Provide food-based learning activities and recipe demonstrations.
- Provide home-visiting to eligible families. (Track number served.)
- 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. (Track outcomes.)

* Anticipated measurable outcome(s):

- Decrease the infant mortality rate in Cuyahoga County (baseline: 8.1 per 1,000 live births in 2017). 
- Decrease preterm births (less than 37 weeks gestation) in Cuyahoga County (baseline: 11.9% in 2018). 

Indicator(s) used to measure progress:

- Infant mortality rate in Cuyahoga County, also by race (ODH, Vital Statistics on the Healthy NEO website: <http://www.healthyneo.org/>) 
- Rate of preterm births in Cuyahoga County, also by race (ODH, Vital Statistics on the Healthy NEO website: <http://www.healthyneo.org/>) 
- UH Centering Pregnancy outcomes, also by race:
 - Rate of very premature births (< 32 weeks)
 - Percent of low weight births
 - Breastfeeding rates

Collaboration and Partnerships: Centering Healthcare Institute, The Centers for Families and Children, First Year Cleveland, Sodexo, Birthing Beautiful Communities, Greater Cleveland Food Bank

** Outcomes are based on a variety of tactics occurring among Cuyahoga Community Health Partners to achieve the anticipated results at the county level.*



STRATEGIES

University Hospitals St. John Medical Center

CHNA Priority: Chronic Disease Management and Prevention

Strategy 1:

- Community-based education, health screenings and physical activities to prevent and/or manage chronic diseases

Goal:

- Improve wellbeing of adults in Cuyahoga County via chronic disease prevention and providing tools for disease self-management, particularly for diabetes and heart disease.

Objectives: By December 2022

- Screen at least 1,500 individuals annually.
- Promote healthy lifestyle choices to at least 1,000 individuals annually through exercise programs, weight loss programs and nutrition education.
- Increase awareness and education of chronic disease self-management skills to 1,500 individuals annually.

Action Steps:

Year 1

- Continue to host Family Health & Safety Days and participate in health fairs throughout the city, emphasis on addressing diabetes and heart disease. (Track number of participants, screenings, and positive screening results.)
- Provide free screenings in the community at faith-based organizations, senior centers, community centers, etc. to increase early detection of chronic diseases; emphasis on reaching populations with barriers to access health care.
- Host a monthly Mall-Walker group. (Track number of participants.)
- Provide a variety of workshops in schools regarding hand-washing safety to prevent illness, smoking/vaping cessation; and mentoring/shadowing experiences with Lorain High School students in partnership with Lorain County Community College. (Track number of participants and type of activity.)
- Provide screenings and education to raise awareness regarding behaviors that decrease high blood pressure. (Track number of participants, screenings and positive screening results.)
- Provide nutritional demonstrations and health talks, and physician talks regarding healthy lifestyle choices. (Track number of participants.)

Years 2-3

- Continue Year 1 activities.
- Re-develop and implement a weight management program, emphasis on diabetes prevention and maintenance.

*** Anticipated measurable outcome(s):**

- Reduce (or maintain) the percent of Cuyahoga County adults age 20+ years who have ever been diagnosed with diabetes (baseline: is 9.3% in 2016). 📊
- Reduce (or maintain) the percent of Cuyahoga County adults age 20+ years who are obese in Cuyahoga County (baseline: 30.2% in 2016).
- Reduce (or maintain) the age-adjusted death rate due to coronary heart disease in Cuyahoga County (baseline: 114.8 per 100,000 from 2015-2017). 📊

Indicator(s) used to measure progress:

- Percent of Cuyahoga County adults age 20+ years who have ever been diagnosed with diabetes, also by race (Centers for Disease Control on the Healthy NEO website: <http://www.healthyneo.org/>) 📊
- Percent of Cuyahoga County adults age 20+ years who are obese, also by race (Centers for Disease Control on the Healthy NEO website: <http://www.healthyneo.org/>)
- Age-adjusted death rate due to coronary heart disease in Cuyahoga County, also by race (Centers for Disease Control on the Healthy NEO website: <http://www.healthyneo.org/>) 📊
- Percent of Cuyahoga County adults age 65+ years on Medicare who are treated for hypertension (58.2% in 2017, Centers for Medicare and Medicaid Services on the Healthy NEO website: <http://www.healthyneo.org/>)
- Program evaluation form to include a question regarding perception of organizational trustworthiness as a community-engaged partner

Collaboration and Partnerships: American Diabetes Association, American Heart Association, Colorectal Cancer Alliance, Crohns and Colitis Foundation of America, Cuyahoga County Board of Health, Far West, Porter Public and Lakewood Public Libraries; The Gathering Place, United Way, The Department of Veterans Affairs, Westlake Senior and Community Services, Westlake Food Pantry, Westshore Family YMCA, Local Senior Centers, Great Northern Mall, Bay Village City School District, North Olmsted City Schools, Westlake City School District, Area Extended Care Facilities, Westside Healthcare Organization, Fire Stations, Westlake Recreation Center, American Cancer Society, Rite Aid, Fairhill Partners, City of Westlake

** Outcomes are based on a variety of tactics occurring among Cuyahoga Community Health Partners to achieve the anticipated results at the county level.*

University Hospitals St. John Medical Center
CHNA Priority: ** Enhance Trust
Strategy 1: <ul style="list-style-type: none"> • Strategic partnerships and community engagement to build and/or maintain trust
Goal: <ul style="list-style-type: none"> • Establish new relationships with employers, social service agencies and community groups.
Objectives: By December 2022 <ul style="list-style-type: none"> • Build relationships with at least three new organizations annually. • Continue to foster and strengthen existing relationships.
Action Steps: Years 1-3 <ul style="list-style-type: none"> • Identify and initiate strategic partnerships with three new local organizations annually. (Track new partnerships.) • Co-design and implement events with different stakeholders to improve health outcomes and build community, emphasis on employers, social service agencies and schools; being inclusive of opportunities for varying age categories and lived experiences. (Track events and number of participants.) • Develop a partner survey to assess trustworthiness as a community-engaged stakeholder, to include input from the Patient and Family Advisory Council.
* Anticipated measurable outcome(s): <ul style="list-style-type: none"> • More inclusive community programming to address diverse needs • Increased perception of UH St. John Medical Center as an engaged community stakeholder
Indicator(s) used to measure progress: <ul style="list-style-type: none"> • Program evaluation forms regarding organizational perception of trustworthiness, includes questions to capture suggested programs, interest in joining a planning team (UH St. John Medical Center survey) • Patient experience survey results regarding their willingness to recommend UH St. John Medical Center to other people (Press Ganey) • New relationships formed with organizations (UH St John Medical Center self-assessment) • New/different types of interventions that emerge based on stakeholder participation (UH St John Medical Center self-assessment)
Collaboration and Partnerships: TBD based on strategy

** Outcomes are based on a variety of tactics occurring among Cuyahoga Community Health Partners to achieve the anticipated results at the county level.*

** St. John Medical Center initially selected *Mental Health/Substance Abuse Reduction* as one of its priorities but changed its focus to *Enhance Trust* prior to the development of the IS. This was done for several reasons. Firstly, this priority was not selected by any of the other UH hospitals as a stand-alone focus area so there was a need. Secondly, most of UH St. John Medical Center's efforts regarding substance use/misuse are being addressed through its traditional clinical services which do not meet the IRS definition of a "community benefit." Thirdly, this strategy will expand the hospital's reach and depth of engagement in the community, which aligns with its unique faith-based mission, along with its ongoing provision of excellence in patient care.

Other UH Community Health Initiatives

University Hospitals has contributed nearly \$3 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, 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. UH 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 14 years. Its goals are: Buy Local, Live Local, Hire Local and Connect. Since 2014, UH has spent over \$5.8 million in services to support Evergreen Cooperatives in a conscious effort to invest in local companies. It also encourages employees to become residents in GUC through home purchasing, rental assistance and exterior upgrades and repairs through the Greater Circle Living program; UH has provided over \$1,000,000 since 2014. As a result, nearly 170 employees have taken advantage of this strategic initiative to attract and retain residents in the city of Cleveland. Lastly, since 2013, more than 450 community residents have been hired at UH through the Step Up to UH and Pathway programs.

Supplier Diversity

In 2019, UH's local preference resulted in over \$482 million in procurement spending with vendors in Northeast Ohio and over \$239 million in the city of Cleveland. Additionally, in 2019, Minority- and Female-owned Business Enterprises exceeded \$35 million, for a total of over \$785 million.

Lead Safe Cleveland Coalition (LSCC) and First Year Cleveland (FYC)

UH remains actively engaged in regional initiatives addressing lead-safe homes and infant mortality. There are dedicated leaders from UH Rainbow Babies & Children Hospital's pediatric division and the office of UH Government and Community Relations serving on the policy committee for LSCC. Additionally, several leaders chair FYC committees, including the head of the office of UH Community Impact, Equity, Diversity and Inclusion (CEDI), who co-chairs the FYC Action Team focused on implicit bias training and the president of UH Rainbow Babies & Children's Hospital who is the co-chair for FYC's Executive Committee.

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 3,000 patients annually.

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.

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.

Numerous events have been 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.

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 was UH's Vice President of Clinical Integration. The consortium's goal is to share and implement evidence-based practices, promote policy changes and increase prevention efforts related to the opioid epidemic.

During 2019, the Pain Management Institute expanded its activities for clinical care, patient education, and provider education. From enhanced clinical resources to electronic health record improvements and the creation of a new educational webinar series for monthly provider education on pain-related topics, the Institute has expanded its reach significantly. Additionally, as a member of the Cuyahoga County Task Force, the Pain Management Institute participated in numerous UH community outreach events, including Family Health & Safety Days, to educate the community on opioid awareness. Over the course of 2019, members of the Pain Management Institute participated in twelve UH Family Health & Safety Days.

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 its neighbors in the Fairfax community. Its mission is to provide excellence in patient care in a spiritually supportive environment. The Center was established in close partnership with the Olivet Institutional Baptist Church in 1997. This new model of care allows 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. The UH Otis Moss, Jr. Center served nearly 10,000 patients in 2019.

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. Since opening in October of 2018, over 38,000 pounds of food have been provided - an average of 144 pounds per unique household. In roughly 16 months since its inception, it has served 269 new households, reaching nearly 770 individuals.

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 disease, dementia and addictive medicine), urology and 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 health care 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. As of December 2019, the Center provided 127,023 clinical care and pharmacy visits.

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.

The Center provides integrated mental and behavioral health services, nutrition education and health food programs (including counseling provided by dietitians), OneSight, (a full-service vision clinic), dental screening and cleaning, legal services through Medical-Legal partnership with The Legal Aid Society of Cleveland, a WIC (Women, Infants and Children) office and on-site pharmacy.

Emerging Initiatives

In addition to the individual strategies that each organization among the Cuyahoga Community Health Partners is developing to address community health needs, several emerging initiatives are underway that will allow these stakeholders to work collaboratively on what are being described as “aligned strategies.” These aligned strategies will complement the individual strategies underway and bolster the impact that all stakeholders can have to make a deeper impact on addressing the five identified priorities. Furthermore, these strategies demonstrate the progress that local health departments and hospitals have made to align not just their assessments but also their strategies as described in guidance developed by the Ohio Department of Health. The aligned strategies that have been selected in Cuyahoga County align with state population health efforts to address cross-cutting, upstream factors that impact health as described in the 2017-2019 State Health Improvement Plan.

Gaining consensus among all stakeholders was critical when determining which aligned strategies to work on collaboratively and a multi-step process was developed to achieve this which brought together hospitals, public health departments, community residents and other organizations. Goal statements tied to the five identified health priorities were created. Potential aligned strategies tied to the goal statements were developed by stakeholders and several rounds of voting determined: 1) which aligned strategies stakeholders were most interested in pursuing, 2) the number of aligned strategies that should be developed, and 3) the type of organizational resources that could be committed to supporting the development of these strategies. The results of this consensus building process yielded the following two aligned strategies – tied to goal statements and identified priorities – that will be developed from 2020-2022:

Cuyahoga County Aligned Strategies

CHNA Priority: Eliminate Structural Racism (Cross-cutting Factor)

Strategy:

- Co-create a systems-model for change to eliminate structural racism using the Robert Wood Johnson Foundation / Public Health National Center for Innovations grant as a first step.

Goal:

- Develop a cross-sector systems change model to eliminate structural racism as a social determinant of health in Cuyahoga County.

Objective:

- By December 2022, develop short, intermediate and long-term action steps to affect structural racism in Cuyahoga County. Identified action steps will include community-generated ideas on multiple levels, from the neighborhood to organizational, policy and systems change levels.

Action Steps:


Years 1-3

- Develop a core team to develop and facilitate the group model-building sessions and community meetings.
- Employ equity-grounded participatory group model building (GMB) using community-based system dynamics (CBSD) to create a systems-change model to eliminate structural racism for Cuyahoga County. Community partners who have engaged in the selection of the aligned strategy will be included in the group model building work.
- Identify systems interventions that address structural racism and lack of trust through the model.
- Determine measures / indicators to help track progress.

* Anticipated measureable outcome(s):

- A collaboratively-developed model focused on systems change and cross-sector alignment to address structural racism in Cuyahoga County.

Collaboration and Partnerships: Cuyahoga County Community Health Partners and affiliated community-based organizations

Cuyahoga County Aligned Strategies
CHNA Priority: Improve Community Conditions (Cross-cutting Factor) 
<p>Strategy:</p> <ul style="list-style-type: none"> • Develop a multi-organization partnership to better link social service resources and community through technology and on-the-ground strategies.
<p>Goal:</p> <ul style="list-style-type: none"> • Increase power-sharing that creates healthy communities and environments to enable people to live to their full potential.
<p>Objective:</p> <ul style="list-style-type: none"> • By December 2022, better connect patients and community residents to community-based resources that help address their social needs.
<p>Action Steps:</p> <p>Years 1-3</p> <ul style="list-style-type: none"> • Convene stakeholders to determine strategies to better link community with social services (i.e. a community calendar that includes grassroots programming). • Increase access to important health and wellness resources through either the Healthy Northeast Ohio website or the development of a mobile application. • Use learnings from the Data Across Sectors for Health mentorship with 2-1-1 San Diego to inform the development of a shared learning platform.
<p>* Anticipated measurable outcome(s):</p> <ul style="list-style-type: none"> • Dedicated network of decision-makers tasked with identifying and implementing innovative solutions to link Cuyahoga County families to resources addressing social determinants of health. • By December 2022, there will be an established community-wide process and information technology infrastructure for linking social needs of community members/patients with community-based organizations.
<p>Collaboration and Partnerships: Cuyahoga County Community Health Partners and affiliated community-based organizations</p>

Long-term Comprehensive Community Engagement Strategy

In addition, while not identified through the consensus-building process as one of the two aligned strategies, one of the other vitally important elements is to develop a long-term, comprehensive community engagement strategy that begins in 2020 and creates multiple levels of engagement in every part of the assessment and improvement planning process. This will continue to be developed in 2020 and will involve a robust network of community residents and all community health improvement planning organizational partners. This will entail exploring and identifying appropriate outcomes and indicators for measuring trust.

Significant Health Needs Not Being Addressed by the Hospitals

UH Hospitals are implementing strategies along with the Cuyahoga Community Health Partners for all of the priorities identified in the 2019 Joint Cuyahoga County CHNA. Each respective UH medical center is committing resources that build upon the momentum of its prior efforts and in view of other partners' contributions to better leverage limited resources. UH-specific resources and partnerships associated with each priority-need are outlined in the *UH Resource Matrix* (Appendix A).

Although UH medical centers are collectively addressing all five priorities, there are several community health needs listed below that will not be directly or primarily addressed by the hospitals because other county partners are addressing them based on their core expertise, prior experience and/or availability of existing resources. The compiled list of programs and activities offered by the Cuyahoga Community Health Partners can be found in the *2020-2022 Inventory of Current Stakeholder-Specific Programs* in Appendix B. For example:

- No-cost preventative/wellness classes in under-resourced neighborhoods such as tobacco cessation, diabetes support, weight loss and stress reduction
- School-based health services
- Violence prevention efforts
- Long-term, sustainable transportation solutions to increase access to health care

Additionally, some strategies are not included in this IS because they do not meet the IRS definition of a non-profit hospital "community benefit," but are still addressed by the UH System. More specifically, they are required or expected of all hospitals based on licensure or accreditation, are a routine standard of clinical care, or primarily benefit the organization rather than the community. This includes things such as employee in-service training, equal opportunity employer policies and smoke-free workplace policies, or clinical mental health and substance disorder treatment and maternal/ infant health services. Lastly, representatives from University Hospitals are actively engaged members of the Cuyahoga County Community Health Steering Committee and will continue to serve as thought-leaders on an ongoing basis regarding the overarching process of community health improvement.

Community Collaborators

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

Cynthia Bender, MBA, University Hospitals Regional Hospitals
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Vetella Camper, MUPDD, University Hospitals Regional Hospitals
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Chesley Cheatham, M.Ed, MCHES, University Hospitals Seidman Cancer Center
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Robyn Strosaker, MD, FAAP, University Hospitals Cleveland Medical Center
Mary Beth Talerico, MBA, University Hospitals Parma Medical Center
Jennifer Walker, BA, University Hospitals Rainbow Babies & Children's Hospital
Kathryn Wesolowski, BS, University Hospitals Rainbow Babies & Children's Hospital

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

Terry Allan, MPH, Cuyahoga County Board of Health
Romona Brazile, BSN, BA, RN, Cuyahoga County Board of Health
Merle Gordon, MPA, Cleveland Department of Public Health
Heidi Gullett, MD, MPH, Case Western Reserve School of Medicine / HIP-Cuyahoga
Martha Halko, MS, RD, LD, Cuyahoga County Board of Health
Frances Mills, D.Min, MAPT, Cleveland Department of Public Health
Nichelle Shaw, MPH, Cuyahoga County Board of Health
Adam Nation, MPP, MPH, Cleveland Department of Public Health

The following community stakeholders participated in facilitated discussions that yielded the two aligned strategies:

Marilyn Burns, Community Resident
Delores Collins, CCHW, A Vision of Change
Sara Continenza, MPA, Food Strong
Reverend Earnest Fields, PhD, Calvary Hill Church of God in Christ
Cheryl Johnson, AA, Community Resident
Tracy McArthur, BA, PQRST Center
Alexander Robertson, BS, Recess Cleveland
Barbara Wilcher-Norton, MA, Neighbor-to-Neighbor Facilitator / Community Resident

Hospitals

Leslie Andrews, RN, MPA, CDE, St. Vincent Charity Medical Center
Jacque Bailey, PhD, Cleveland Clinic
Nazleen Bharmal, MD, PhD, Cleveland Clinic
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Colletta Somrack, BSN, RN-BC, University Hospitals
Jennifer Walker, BA, University Hospitals Rainbow Babies & Children's Hospital
Kathryn Wesolowski, BS, University Hospitals Rainbow Babies & Children's Hospital
Chantel Wilcox, MBA, Cleveland Clinic

Other

Greg Brown, MS, Policy Bridge
Kirstin Craciun, MPP, MSW, The Center for Health Affairs
Amina Egwierkhor, MD, Case Western Reserve University
Adeola Fakolade, MD, Case Western Reserve University
Candice Kortyka, MBA, The Center for Health Affairs
Jonathan Lever, MPH, NRP, Better Health Partnership
Benjamin Miladin, MSW, United Way of Greater Cleveland
Jill Miracle, MD, Case Western Reserve University
Kurt Stange, MD, PhD, Case Western Reserve University
Patricia Terstenyak, MPH, The Center for Health Affairs

Qualifications of Consultants

The process to develop this IS was facilitated by Kirstin Craciun, Director of Community Outreach, The Center for Health Affairs, and Heidi Gullett, MD, MP, Associate Professor Charles Kent Smith, MD and Patricia Hughes Moore, MD Professorship in Medical Student Education in Family Medicine Center for Community Health Integration, Case Western Reserve University School of Medicine. Dr. Gullett is dually board-certified in Preventive Medicine and Family Medicine and maintains a robust clinical practice at Neighborhood Family Practice on Cleveland's west side. For the past several years, she has been embedded as the CWRU School of Medicine population health liaison at the Cuyahoga County Board of Health. Her responsibilities include building partnerships between public health and clinical care in an effort to achieve health equity through community health improvement. She also serves as co-chair of the Health Improvement Partnership-Cuyahoga (HIP-Cuyahoga), a large cross sector community health improvement consortium.

The report was written by Danielle Price, Director, Community Health Engagement, in the department of Government and Community Relations at University Hospitals and Kirstin Craciun, with input from Leslie Andrews, Diabetes Coordinator, St. Vincent Charity Medical Center and Heidi Gullett, MD, MPH, Case Western Reserve University School of Medicine regarding county-wide outcomes and strategies.

Danielle Price oversees state and federal community benefit compliance for all UH medical centers. She serves on the Cuyahoga County Community Health Steering Committee and the Health Improvement Partnership-Cuyahoga (HIP-Cuyahoga) Steering Committee. She has a Bachelor's degree from the Wharton School of Business, University of Pennsylvania and a

Master of Science in Social Administration (MSSA) degree from the Mandel School of Applied Social Science at Case Western Reserve University.

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 2020-2022 Implementation Strategies for the Cuyahoga Community Health Partners - including 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.

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

Contact

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Appendix A: University Hospitals Resource Matrix

Priority: Eliminating Structural Racism	
Hospital	Resources and Collaborative Partners
Cleveland Medical Center	<ul style="list-style-type: none"> • Community Impact, Equity, Diversity and Inclusion (CEDI), Health Scholars Program <ul style="list-style-type: none"> ○ UH staff, medical residents, space, materials – Health Scholars Program ○ Shaker Heights High School ○ Cleveland School of Science and Medicine ○ Case Western Reserve University
Rainbow Babies & Children/MacDonald Women’s Hospital	<ul style="list-style-type: none"> • UH Rainbow Women & Children’s Center: <ul style="list-style-type: none"> ○ Trauma-Informed Care ○ Unconscious Bias Training
Priority: Enhancing Trust	
St. John Medical Center	<ul style="list-style-type: none"> • UH staff, expertise, materials
Priority: Improving Community Conditions	
Ahuja Medical Center	<ul style="list-style-type: none"> • UH staff, space, materials • Breakfast with Santa resource event • Cleveland library system
Bedford-Richmond Medical Centers	<ul style="list-style-type: none"> • UH financial counseling staff, ED providers, primary care offices • UH community outreach staff addressing safety
Cleveland Medical Center	<ul style="list-style-type: none"> • Adult Trauma Program, Violence Interrupters Program <ul style="list-style-type: none"> ○ Cleveland Peacemakers/City of Cleveland ○ UH Emergency Medical Services Institute
	<ul style="list-style-type: none"> • Community Impact, Equity, Diversity and Inclusion (CEDI), Food for Life Market <ul style="list-style-type: none"> ○ UH Staff, space ○ Sodexo ○ Olivet Institutional Baptist Church
	<ul style="list-style-type: none"> • UH Harrington Heart and Vascular Institute staff to support inner city health education/career development programs • UH staff including UH Emergency Medical Services Institute to provide heart failure CPR/safety training and Stop the Bleed Program and Cardiac Arrest Free Zones • Breakthrough Schools • Local first responders
	<ul style="list-style-type: none"> • UH Emergency Medical Services Institute injury prevention programs for all ages <ul style="list-style-type: none"> ○ Fire departments; mayors, safety directors, school districts
Parma Medical Center	<ul style="list-style-type: none"> • UH Emergency Medical Services Institute Stop the Bleed Program, Safety Fair, Meals on Wheels, Free Screenings, Free Summer Lunch Program • Cities of Parma, North Royalton, Parma Heights, Seven Hills, Brooklyn, Brooklyn Heights and Broadview Heights • Brecksville-Broadview Hts., North Royalton and Parma City School Districts • North Royalton Family YMCA • Padua High School • Parma Area Family Collaborative • Parma Branch – Cuyahoga County Public Library • Partnership for a Healthy North Royalton • St. Albert the Great • Senior centers • The Arthritis Foundation • West Creek Conservancy; • YMCA of Greater Cleveland

<p>Rainbow Babies & Children/MacDonald Women’s Hospital</p>	<ul style="list-style-type: none"> • UH Rainbow Women & Children’s Center: <ul style="list-style-type: none"> ○ Rainbow Connects ○ Community Nutrition Education ○ Centering Pregnancy • UH Rainbow Kids Free Summer Lunch Program • UH Rainbow Injury Prevention Center • UH Rainbow Kids Free Weekend Meal Program • UH Department of Psychiatry • Bright Beginnings • Catholic Charities of Ashtabula County • Child Abuse & Neglect Prevention: Ohio Children’s Trust Fund Great Lakes Regional Prevention Council • Cleveland Housing Network • Cleveland Neighborhood Progress • Dave’s Markets Community Kitchen Programs • Family Pride of Northeast Ohio • First Year Cleveland • Furniture Bank • Healthy Harvest, Kitchen demonstrations and events • May Dugan Center • MidTown Cleveland • Ohio Attorney General’s Office • Ohio Department of Education • Ohio State University Extension • Pediatric Trauma/Pediatric Emergency Department Antifragility Initiative • Safe Kids Coalition • Women, Infants, and Children • Womensafe, Inc. • YWCA of Greater Cleveland
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Chronic Disease Prevention / Management

<p>Ahuja Medical Center</p>	<ul style="list-style-type: none"> • UH Diabetic Self-Management Education classes • UH staff: health professionals talks, wellness seminars, support groups, screenings • Stop the Bleed and CPR training • UH Age Well Be Well program • Alert Care Medical Systems Dementia Care • Alzheimer’s Association • American Cancer Society • American Heart Association • Arden Courts, Chagrin Falls Dementia Care • Arthritis Foundation • Beachwood Fire Department • Beachwood High School • City of Beachwood • City of Bedford • City of Highland Hills • City of Solon • City of Warrensville Heights • Cleveland Library system – Orange Library • Cuyahoga Community College • Cuyahoga County Board of Health • Cuyahoga County Opiate Task Force • Diabetes Association • Empowering Epilepsy
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	<ul style="list-style-type: none"> • Health Improvement Partnership - Cuyahoga • Hospice of the Western Reserve at UH • Job and Family Services • Lifebanc • Maltz Museum • Montefiore and the Weils • Ohio Library for the Blind & Physically Disabled • Orange Senior Center • Ostomy Awareness WOC • The Gathering Place • Twinsburg High School • UH Bariatrics • UH Dermatology • UH EMS Institute • UH Home Care Services • UH Orthopedics • UH Physical Therapy • Warrensville Heights Senior Center • Warrensville Heights Family YMCA • YMCA of Greater Cleveland
Beachwood Rehabilitation Hospital	<ul style="list-style-type: none"> • UH staff, space for support groups, partner with UH physicians
Bedford-Richmond Medical Centers	<ul style="list-style-type: none"> • UH staff in varying departments: dieticians, nurses, EMS Institute, respiratory therapists • Community Partnership on Aging • Partnerships with local churches, nursing facilities, senior centers, local government • Partnerships with police and fire departments, local businesses, Cuyahoga County public library, educational institutes, local schools
Cleveland Medical Center	<ul style="list-style-type: none"> • UH Harrington Heart and Vascular Institute staff • Emergency Medical Services Institute staff <ul style="list-style-type: none"> ○ Education and health screening pertaining to cardiovascular disease prevention and early detection • UH Seidman Cancer Center staff • American Cancer Society • Cleveland Clinic • Cleveland Public Health Department • City of Cleveland • Health Improvement Partnership-Cuyahoga • Healthy Cleveland • MetroHealth System
Parma Medical Center	<ul style="list-style-type: none"> • UH physician presentations, events, smoking cessation classes to high schools • Health Education Center – offering free space for local agency support groups • Alzheimer’s Association • Amelia Foundation • American Heart Association • Community health fairs • Food Addicts Anonymous Foundation • North Royalton City Schools • North Royalton Family YMCA • Ohio Parkinson’s Foundation • Padua High School • Parma Area Family Collaborative • Parma Branch – Cuyahoga County Public Library

	<ul style="list-style-type: none"> • Parma City School District • Partnership for a Healthy North Royalton • St. Albert the Great • Senior centers in UH Parma service areas • The Arthritis Foundation • West Creek Conservancy; • YMCA of Greater Cleveland
St. John Medical Center	<ul style="list-style-type: none"> • UH staff time, screening supplies, and event materials, printed materials • Area extended care facilities, local senior centers, Great Northern Mall, Bay Village City School District, North Olmsted City Schools and Westlake City School District and fire stations • American Cancer Society • American Diabetes Association • American Heart Association • City of Westlake • Colorectal Cancer Alliance • Crohns and Colitis Foundation • Cuyahoga County Board of Health • Far West, Porter and Lakewood Public Libraries • Fairhill Partners • Rite Aid • The Gathering Place • United Way • Department of Veterans Affairs • Westlake Community Services • Westlake Food Pantry • West Shore Family YMCA • Westside Healthcare Organization • Westlake Recreation Center
Improving Mental Health / Reducing Addiction	
Ahuja Medical Center	<ul style="list-style-type: none"> • UH Connor Integrative Network • UH Pain Management Institute • UH staff: Music Therapy
Bedford-Richmond Medical Centers	<ul style="list-style-type: none"> • UH staff • UH Connor Integrative Health Network
Cleveland Medical Center	<ul style="list-style-type: none"> • Pain Management Institute & UH Department of Psychiatry <ul style="list-style-type: none"> ○ UH Addiction Services
Rainbow Babies & Children/MacDonald Women's Hospital	<ul style="list-style-type: none"> • UH Rainbow Women & Children's Center: <ul style="list-style-type: none"> ○ Mom Power Program ○ UH MOMs (Maternal Opiate Medical Support) program • LifeAct

Appendix B: 2020-2022 Inventory of Current Stakeholder-specific Programs that Relate to the 5 Priorities

2019 CHNA Priorities	Strategy/Program	CCBH	CDPH	Metro	St. Vin.	SW	UH
Overarching Priorities							
Structural Racism*	Creating Healthy Communities Program - Supermarket Access	X					
	Maternal and Child Health Program	X	X				
	Racial and Ethnic Approaches to Community Health	X	X				
	EDI Training in Internal Workforce Development		X				
	Annual Internal Cultural Competence Training		X			X	
	Race, Ethnicity and Language		X	X			
	Health Literacy Institute		X		X		
	All policies and procedures do not discriminate on race, sex, religion					X	
	Health Scholars						X
	Trauma-Informed Care/Bias education		X				X
	Centering Pregnancy						X
	Breast and Cervical Cancer Prevention Program	X					X
	Creating Healthy Communities Program - Supermarket Access	X					
	Lead Safe Cleveland Coalition Membership		X				
Gain Health Literacy Champion Designation		X					
Collection of Client/Patient Satisfaction Data		X					
Institute for H.O.P.E.				X			
EcoDistrict				X			
Buckeye Community Resource Center				X			
Reverse Ride Along through the Sisters of Charity Foundation for caregivers/medical residents. Community based initiative to build trust and collaboration between the medical professionals and the community they serve					X		
Community Advisory Board					X	X	
Health Navigator					X	X	
24/7 hot-line to connect community members to critical care nurse and NPs						X	

Trust**

2019 CHNA Priorities	Strategy/Program	CCBH	CDPH	Metro	St. Vinc.	SW	UH
Community Health	Web-based social media platform to educate individuals on the programs at Southwest - Working with local communities to help bridge the gaps in care and education					X	
	Multiple support groups for heart failure, cardiac arrest, mental health					X	
	Educational talks, support groups, connection					X	X
	Community Conditions						
Poverty	Racial and Ethnic Approaches to Community Health	X	X				
	Ryan White HIV/AIDs Part A	X					
	Healthy Homes Program	X	X				
	Creating Healthy Communities Program	X					
	Monthly Mobile Food Pantry		X				
	Open Table			X			
	Medical-Financial Partnership (with ESOP)			X			
	Financial Counseling				X	X	
	Medical Legal Partnership				X		
	Food Insecurity Screener				X		
	Medication assistant program for patients with cancer					X	
	Transportation for those who need rides to appointments					X	
	Free screenings -basic health					X	
	Youth Summer Lunch Program						X
	Education on financial assistance programs						X
	Step Up to UH						X
	Health Scholars Internship & Beachwood Medical Academy						X
	Food for Life Market						X
	Meals on Wheels program						X
	Community resource fair: Breakfast with Santa						X
Rainbow Connects, social determinant of health screening and support services						X	
Dental van						X	

2019 CHNA Priorities	Strategy/Program	CCBH	CDPH	Metro	St. Vinc.	SW	UH	
Homicide/Violence/Safety	Continue to convene the Healthy Cleveland Initiative Violence Prevention Committee		X					
	Violence Interrupters (via NOTS - Northern Ohio Trauma Systems)			X			X	
	Trauma Recovery Center			X				
	Center for Community Health Resilience			X				
	Healing Circles (Faith-based Outreach)			X				
	Mental health support groups		X			X		
	Community nurse education					X		
	Working with local high schools for prevention education					X		
	Stop the Bleed						X	
	Community Conditions							
Transportation	Racial and Ethnic Approaches to Community Health	X						
	Ryan White HIV/Aids Part A	X						
	Safe Routes to School	X	X					
	Bus Tickets for Outpatient/Inpatient				X			
	Lyft services for hospital discharge and outpatient programs				X	X		
	Elite Medical Transportation Solutions for outpatient services				X			
	Transportation program that provides rides within our taxing district to and from appointments					X		
	Bus passes					X	X	
	Chronic Disease							
	Cardiovascular Disease	Creating Healthy Communities Program	X					
Racial and Ethnic Approaches to Community Health		X	X					
Farm to School		X						
Ohio Healthy Program		X						
Early Ages Healthy Stages Coalition		X						
Tobacco 21		X	X					
Collect and report neighborhood level data on heart disease incidence and mortality								
Smoking cessation			X	X			X	

2019 CHNA Priorities	Strategy/Program	CCBH	CDPH	Metro	St. Vinc.	SW	UH	
Cardiovascular Disease	Community-Clinical Linkages (via BHP)			X				
	Community Health Screenings/Education				X			
	Medication Therapy Management in Outpatient Pharmacy				X	X		
	Coumadin Clinic				X	X		
	Stroke Prevention Screening					X		
	Tobacco Screening					X		
	Chronic care clinic that provides care for those individuals who need extra assistance					X		
	Telemedicine for our HF and COPD patients-Healthy eating programs- Healthy Heart, Grey Matters, Circulation Circuit-Full cardiovascular screenings					X		
	Transitional nurse program that will go into the patients home after discharge from the hospital-Navigator role for Chronic Care Services					X		
	Health education and screenings (includes cancer / Seidman's new mobile health unit)					X	X	
	Nutrition outreach program at Dave's Markets teaching kitchen						X	
	School and community-based career/health education					X	X	
Diabetes	Collect and report neighborhood level data on diabetes incidence and mortality		X					
	VIDA!			X				
	Food As Medicine			X				
	Diabetes Self-Management			X		X		
	Fresh Produce Distribution		X	X				
	Diabetes Inpatient/Outpatient Education Program				X	X		
	Diabetes Support Group				X	X		
	Political Advocacy through the American Association of Diabetes Educators Ohio Board					X		
	Community Health Screenings/Education					X	X	

2019 CHNA Priorities	Strategy/Program	CCBH	CDPH	Metro	St. Vinc.	SW	UH
Diabetes	Free screening for patients to detect diabetes					X	
	Community nurses education					X	
	Comprehensive wound care program					X	
	Screenings					X	X
Mental Health / Addiction							
Suicide	Mental Health - Social Emotional Health – Adverse Childhood Experience testing	X	X				
	School Health Program/SAFE (Students Are Free to Express)			X			
	Comprehensive inpatient and outpatient services					X	
	Strongsville and Columbia High School education programs					X	
Substance/Opioid Use Disorder	Cuyahoga County Overdose Data to Action (OD2A) Initiative	X					
	CenterPoint (Outpatient Treatment Groups)		X				
	Project Dawn (Narcarn / Opioid Education)		X				
	Office of Opioid Safety - multiple programs			X			
	Project DAWN (Deaths Avoided with Naloxone)		X	X			
	Psychiatric Emergency Department				X		
	Rosary Hall Lyft Program				X		
	Addiction Education Family Sessions				X	X	
	Hospital-wide Screening Brief Intervention and Referral to Treatment (SBIRT)				X		
	Tele-psychiatry Pilot				X		
	Integrated Care Pilot (integrating primary care, addiction medicine, mental health)				X		
	Partial Hospitalization Program				X		
	Breakthrough program - Participating in Safe Passages Program						X

2019 CHNA Priorities	Strategy/Program	CCBH	CDPH	Metro	St. Vinc.	SW	UH
	Comprehensive inpatient and outpatient services including adolescents - intake/Assessment team in the ED					X	
	ED adopted guidelines for prescribing opioids, no replacement for lost prescriptions, Ohio automated RX reporting system					X	
	Education and awareness of opiate abuse		X				X
	Awareness of non-pharmacological pain management						X
	UH MOMS (Maternal Opiate Medical Support)						X
	Northeast Ohio Hospital Opioid Consortium			X	X		X
	Mom Power (Group parenting / mental health intervention)						X
Other Mental Health	Stress reduction classes: Mindfulness, acupuncture, massage, music therapy						X

***Structural Racism: Racial bias across and within society. The cumulative and compounded effects of a range of factors such as public policies, institutional practices, cultural representations, and other norms that work in various, often reinforcing ways to maintain racial inequity**

****Trust**

- between Hospital/Public Health Systems and Residents
- between Clinicians and Patients
- between Social Service Agencies / Community Stakeholders and Hospitals