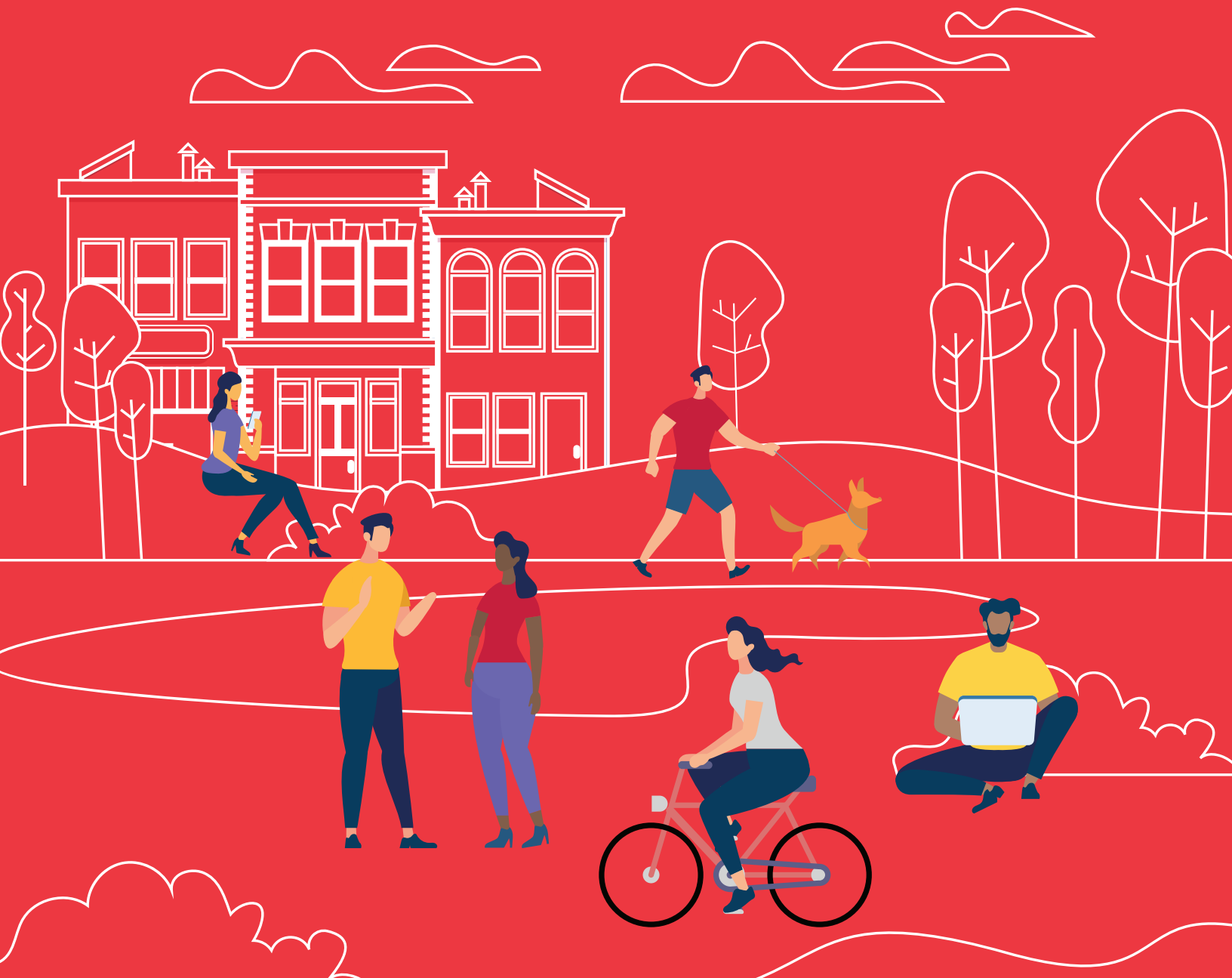
University Hospitals

2023–2025 Community Health Implementation Strategy

UH Ahuja Medical Center
Beachwood RH, LLC
(UH Rehabilitation Hospital)
UH Cleveland Medical Center
UH Parma Medical Center
UH Rainbow Babies & Children's Hospital
UH St. John Medical Center
Cuyahoga County, Ohio



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Adoption by the Board

University Hospitals adopted the 2023-2025 Community Health Implementation Strategy on March 21, 2023. 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)
- 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
- 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 Steering Committee

- A Vision of Change
- Better Health Partnership
- Case Western Reserve University
- Case Western Reserve University School of Medicine
- Cleveland Clinic
- Cleveland Department of Public Health
- Cuyahoga County Board of Health
- Cuyahoga County Clerk of Courts
- Cuyahoga County Department of Health and Human Services
- The MetroHealth System
- Neighborhood Family Practice
- PolicyBridge
- Southwest General
- St. Vincent Charity Medical Center
- The Center for Health Affairs
- United Way 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." by providing a wide range of community benefits including clinical services, community health improvement programs, 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 2022, University Hospitals Ahuja Medical Center, Beachwood RH, LLC (UH Rehabilitation Hospital), 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 2022 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. Together the CHNA and IS serve to align hospital resources and activities to address health needs identified in the CHNA.

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 2022 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. In addition, as the CHNA was conducted collaboratively, UH recognizes needs identified in the CHNA may be better aligned with other key community organizations. In those circumstances other community organizations may be better suited to addressing and leading initiatives to address the needs identified in the CHNA.

Key partners across Cuyahoga County played an important role in collaborating to conduct the joint assessment and include: the Cleveland Clinic, the Cleveland Department of Public Health, Cuyahoga County Board of Health, Case Western Reserve University School of Medicine, The MetroHealth System, Southwest General Health System, St. Vincent Charity Medical Center, and The Center for Health Affairs.

Alignment with Local and State Standards

Ohio law requires local health departments (LHDs) and tax-exempt hospitals to submit their Community Health Improvement Plans and Implementation Strategy reports to the Ohio Department of Health (the department). As of January 1, 2020, Ohio law also requires LHDs and tax-exempt hospitals to complete assessments and plans "in alignment on a three-year interval established by the department." Additionally, local hospitals must align with the Ohio State Health Assessment (an "SHA") and Ohio State Health Improvement Plan (an "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 2020-2022 SHIP.

Community Definition

UH provides care to and defines the community served by this IS as the geographical regions encompassing Cuyahoga County. Defining the community at a county level allows the hospitals, public health departments, and non-profit organizations to more collaboratively assess the health needs of patients and the community. It allows for larger scale collective impact specifically with deep rooted issues that have led to health inequities in the community served.

2022 Joint Cuyahoga CHNA Findings

The findings of the CHNA report are the product of a process facilitated by Conduent Healthy Communities Institute that began with collection and analysis of local data and incorporated other local, regional, state, and national data sources where possible. Additionally, qualitative data was collected through 32 key informant interviews, as well as three separate focus group discussions to gather community input. To better target and understand Cuyahoga County's most pressing needs, a total of 118 community members and leaders participated in community conversations to discuss need prioritization.

The findings of the CHNA report are the product of a process facilitated by Conduent Healthy Communities Institute that began with collection and analysis of local data and incorporated other local, regional, state, and national data sources where possible. Additionally, qualitative data was collected through 32 key informant interviews, as well as three separate focus group discussions to gather community input. To better target and understand Cuyahoga County's most pressing needs, a total of 118 community members and leaders participated in community conversations to discuss need prioritization

The findings of the CHNA bring into focus the foundational issues impacting the health of Cuyahoga County residents. The three priority areas identified in the assessment are:

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

Eliminating structural racism and enhancing trust across sectors, people, and communities, will continue to be overarching areas for work in Cuyahoga County. These priorities informed the design of the UH implementation strategies for 2023-2025.

Strategies

Strategies to Address Health Needs

This IS was developed by UH using findings from the joint Cuyahoga County CHNA and input from community members. UH evaluated magnitude of need, evidence for effective interventions, and consistency with UH strategy. The strategies listed on the following pages delineate University Hospitals' specific strategies to address the three priority needs and overarching areas of work identified in the joint CHNA and any 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: Community Conditions
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 2025.
Action Steps: **Resources** *(track number of attendees and type of resources provided)* • Host resource fairs for individuals under the age of 18 in collaboration with community partners **Food Security** *(track number of participants)* • Partner with Sodexo to offer a free Summer Lunch Program for children 18 years of age and younger • Offer nutrition opportunities in connection with chronic disease (such as heart disease, diabetes, obesity) to our communities (for example high school, community centers, senior centers, expos, wellness seminars) **Safety** *(track number of participants)* • Partner with schools and municipalities to provide "Stop the Bleed" training to educate individuals on gun safety and injury prevention in "active shooter" situations **Youth Workforce Development** *(track number of participants)* • Host resource fairs for individuals under the age of 18 in collaboration with community partners
***Anticipated Measurable Outcome(s) based on current trends: By December 2025:** • Maintain the downward trend of the percentage of Cuyahoga County children living below the poverty level (baseline: 24.8%, 2016-2020) • Maintain the downward trend of people in Cuyahoga County living below the poverty level (baseline: 17.1%, 2016-2020)
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, Bainbridge, Warrensville Heights, Highland Hills, Solon, Orange, Mayfield Heights, Twinsburg, Chagrin Falls, Cleveland Heights, University Heights, North Randall, Shaker Heights, Beachwood, Pepper Pike, Lyndhurst, Richmond Heights, Highland Heights; Sodexo; Breakthrough School System; NSL Analytical Corporation; and other 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: UH Wellness Centers at Richmond & Bedford Health Center
CHNA Priority: Community Conditions
Strategy 2: Strategic partnerships and programming to address social determinants of health.
Goal: Reduce the percentage of patients who report they cannot access enough healthy food for themselves or their children and provide additional social support as needed.
Objective: Utilize Community Health Worker to screen at-risk patients for food insecurity and other essential social needs (baby supplies, utilities, eviction prevention, etc.).
Action Steps: • Host monthly cooking classes in collaboration with Sodexo chefs and dietitians at the UH Wellness Center at Bedford Health Center and UH Wellness Center at Richmond Health Center • Screen for food insecurity and assist families in obtaining necessary resources (include notes regarding number of food insecure, referrals, etc., in Comments) • Continue to provide healthy foods to families through the Food for Life market at UH Wellness Center at Richmond Health Center
***Anticipated measurable outcome(s):** • Maintain the downward trend of the percentage of Cuyahoga County children living below the poverty level (baseline: 24.8%, 2016-2020) • Maintain the downward trend of people in Cuyahoga County living below the poverty level (baseline: 17.1%, 2016-2020)
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/)
Collaboration and Partnerships: Sodexo/Food for Life Market

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University Hospitals Ahuja Medical Center
CHNA Priority: Accessible and Affordable Health Care
Strategy: Raise awareness about appropriate hospital utilization options and provide community-based education, health screenings and support groups to advance health equity in Cuyahoga County.
Goal: Improve well-being of individuals by increasing access to care by removing identified barriers through health literacy and screenings.
Objective: Increase awareness and education of chronic disease prevention and management to improve health literacy and health outcomes.
Action Steps: • Offer health education talks, support groups and resources for our community partners related to chronic disease *(track the number of participants and type of events)* • Conduct screenings at corporations, YMCA, schools, temples, churches, senior centers, low-income apartments, community health fairs and rehabilitation centers *(track the number of events and participants screened)* • Host or participate in a men's health fair(s) • Work with partners to identify strategies and resources specifically targeting social determinants of women's health, such as host or participate in women's health events
***Anticipated Measurable Outcome(s) based on current trends:** By December 2025 • Reduce (or maintain) the percent of adults age 20+ years who have ever been diagnosed with diabetes (baseline: 9% in 2019) • Reduce (or maintain) the age-adjusted death rate due to coronary heart disease (baseline: 105.7 per 100,000 from 2018-2020) • Reduce (or maintain) the percent of adults age 20+ years who are obese in Cuyahoga County (baseline: 34.2% in 2019)
Indicator(s) used to measure outcomes: • 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/) • 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/)
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, 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, UH EMS Institute

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University Hospitals Ahuja Medical Center: UH Wellness Centers at Richmond & Bedford Health Center
CHNA Priority: Accessible and Affordable Health Care/Community Conditions
Strategy: Raise awareness about appropriate hospital utilization options and provide community-based education, health screenings and support groups to advance health equity in Cuyahoga County.
Goal: Assist patients with navigating systems of care to attain necessary social services and provide community space for job training, wellness classes, support groups, etc.
Objective: Increase awareness and education of chronic disease prevention and management to improve health literacy and health outcomes.
Action Steps: • Screen patients for social determinants of health and provide or refer them to appropriate social service providers • Establish strategic partnerships and host events targeting underserved populations to increase health education and access
***Anticipated Measurable Outcome(s) based on current trends:** • Increase the percentage of food insecure patients who are connected to emergency food and essential community resources like the Food Bank and Food for Life Market • Increase the percentage of patients who are connected to other social resources to assist with utility and rental assistance, and health education
Indicator(s) used to measure outcomes: • Patient registration data at Wellness Centers for programming and Food For Life Market
Collaboration and Partnerships: Sodexo/FFL, The Greater Cleveland Food Bank

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Strategies

University Hospitals
Rehabilitation Hospital

A Joint Venture with Kindred Healthcare

Beachwood RH, LLC (UH Rehabilitation Hospital)
CHNA Priority: Accessible and Affordable Health Care
Strategy: Access to community based education and health screening to prevent and/or manage chronic diseases.
Goal: Improve wellbeing of adults in Cuyahoga County via disease prevention and management, particularly stroke victims.
Objective: Screen at least 250 individuals annually, and increase awareness and education regarding stroke prevention and overall wellness for 500 individuals annually.
Action Steps: • 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.) • Host a stroke awareness event for World Stroke Day in October. (Track number of participants.)
***Anticipated Measurable Outcome(s) based on current trends:** • Reduce (or maintain) the age-adjusted death rate in Cuyahoga County due to coronary heart disease (baseline: 105.7 per 100,000 from 2018-2020)
Indicator(s) used to measure outcomes: • 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/)
Collaboration and Partnerships: Partnership with UH Medical Centers, UH physicians and physical therapists

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Strategies

Harrington Heart and Vascular Institute
CHNA Priority: Accessible and Affordable Health Care
Strategy: Community-based education and health screenings to increase access.
Goal: Reduce the incidence of cardiovascular disease among Cuyahoga County residents.
Objectives: By December 2025 • Increase calcium score screenings • Increase reach with under-resourced populations • Increase community knowledge regarding prevention of heart disease and/or management of chronic disease for diagnosed individuals
Action Steps: • Annually host 50 physician-led 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) based on current trends:** • Reduce (or maintain) the age-adjusted death rate in Cuyahoga County due to coronary heart disease (baseline: 105.7 per 100,000 from 2018-2020) • Reduce the age-adjusted death rate due to cardiovascular disease (baseline: 204.4 per 100,000 in 2017)
Indicator(s) used to measure outcomes: • 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/) • Age-adjusted death rate due to cardiovascular disease in Cuyahoga County (http://www.healthyneo.org/) • Calcium score screenings conducted (UH data)
Collaboration and Partnerships: American Heart Association, Breakthrough Schools, Cuyahoga County Metropolitan Housing Authority Hunger Network, Ursuline College, City of Cleveland

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Harrington Heart and Vascular Institute
CHNA Priority: Community Conditions (Community Safety)
Strategy: Community safety training.
Goal: Increase the survival rate of victims of gun violence at schools, and increase the survival rate of individuals experiencing cardiac arrest.
Objectives: By December 2025 • 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
Action Steps: • 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.) • Continue to provide youth violence prevention programs and activities (track number of events and participants) • Host a survivor's dinner • Offer workshops on the dangers of vaping
***Anticipated Measurable Outcome(s) based on current trends:** • Increase the number of survivors of gun violence • Increase the number of survivors of cardiac arrest
Indicator(s) used to measure outcomes: • Survival rates for gun-related injuries; also by race (Internal UH Trauma Department data) **Collaboration and Partnerships:** Local first responder departments, UH EMS Institute, Case Western Reserve University, local school districts and public safety agencies, UH Medical Centers

*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 (Seidman Cancer Center)
CHNA Priority: Accessible and Affordable Health Care
Strategy: Strategic partnerships and targeted screening and education among high-risk populations to increase access, and decrease barriers to cancer screening and treatment.
Goals: • Decrease late-stage diagnosis outcomes in breast and colorectal cancer with evidence-based screenings targeting high risk-sub populations. • Reducing barriers to screening • 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
Objectives: By December 2025 • Provide education and screenings to targeted populations • Improve accessibility of cancer screening and education in targeted high-risk populations
Action Steps: • Continue to provide select cancer screenings and education in the current catchment area (Cleveland) with proper education and awareness messaging. (Track number of participants, screenings and positive screening results.) • Participate in events that target high-risk populations (such as Homeless Stand Down event, African American Male Wellness Walk) • Seek additional screening opportunities internally or with community partners to increase outreach efforts
***Anticipated Measurable Outcome(s) based on current trends:** • Decrease (or maintain) the downward trend of age-adjusted death rate due to breast cancer in Cuyahoga County (baseline: 22.9 deaths per 100,000 females, 2016-2020) • Decrease (or maintain) the downward trend of age-adjusted death rate due to colorectal cancer in Cuyahoga County (baseline: 14.3 deaths per 100,000 , 2016-2020)
Indicator(s) used to measure outcomes: • 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: ODH)
Collaboration and Partnerships: Cleveland Department of Public Health, City of Cleveland, Cleveland Clinic Foundation, The MetroHealth System, The Centers

*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 Otis Moss Jr. Health Center
CHNA Priority: Accessible and Affordable Health Care/Community Conditions
Strategy: Co-locate programs and services within a community-based medical center in an under-resourced community.
Goal: Improve overall health outcomes of patients by integrating resources to address social determinants of health.
Objectives: By December 2025 • Reduce food insecurity and prevent chronic disease and/or disease progression for under-resourced patients through the Food for Life Market • Increase access 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: • 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. (Track number served, amount of food distributed.) • Establish strategic partnerships and host events targeting Men's Health. (Track number of participants and events.) • Partner with MedWorks to host annual pop-up medical clinics, open to the public. (Track number served and relevant outcomes.) • Provide walk-in clinic to increase access to care. • Continue to provide community health worker to connect with community members and better connect individuals with resources. (Track number of encounters and/or classes.)
***Anticipated Measurable Outcome(s) based on current trends:** • Maintain the downward trend of people in Cuyahoga County living below the poverty level (baseline: 17.1%, 2016-2020). • Food insecure rate: percent of Cuyahoga County population that experienced food insecurity at some point during the year (baseline: 15%; 2020)
Indicator(s) used to measure outcomes: • 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: Sodexo, Olivet Institutional Baptist Church, MedWorks, Gathering Place, Neurology Brain Center, Cardio-Metabolic Cinema clinic

*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 Violence Interrupter Program
CHNA Priority: Community Conditions (Community Safety)
Strategy: Hospital-based intervention program to serve patients identified and screened during treatment following a non- accidental gun related event. **Goal:** Reduce gun-related community violence, retaliation and recidivism.
Objectives: Following violent incidents, connect all eligible patients to mediation, conflict resolution and community based case management through referral to community based programs and social services at discharge from the ED or in-patient treatment.
Action Steps: **Year 1:** • Continued partnership with Cleveland Peacemakers Alliance to provide outreach workers offering community based services and support to appropriate gun-related victims of violence treated/admitted at University Hospitals Cleveland Medical Center • Engagement of the victim's family and community members during the patient hospital stay to reduce the potential for retaliatory violence • Ongoing referral of victims to outpatient community services to address social determinants of health at the time of discharge **2024-2025:** • Continue Year 1 activities • Seek funding to expand the programs scope beyond the current limitations of residents of the City of Cleveland within the defined age range of 16 to 25 years
***Anticipated Measurable Outcome(s) based on current trends:** • Reduce the violent crime rate in Cuyahoga County (baseline: 869.6 per 100,000 population in 2021) • Reduce the age adjusted homicide rate in Cleveland and Cuyahoga County (baseline: 14.2 per 100,000 population in Cuyahoga County and 28.3 per 100,000 population in Cleveland in 2017) • Reduce the rate of age adjusted gun-related deaths in Cleveland and Cuyahoga County (baseline: 18.3 per 100,000 population for Cuyahoga County and 29.8 per 100,000 for Cleveland in 2017)
Indicator(s) used to measure outcomes: • Number of patient/family consents for community based follow-up and referral. (Cleveland Peacemakers Reports) • Number of patients enrolled in community based programs after discharge. (Cleveland Peacemakers Reports) • Reduction in the number of victims of non-accidental gunshot wounds (GSW) and GSW-related deaths based on prior years reporting and reports from NOTS/City of Cleveland and Cuyahoga County
Collaboration and Partnerships: Cleveland Peacemakers Alliance; Northern Ohio Trauma System (NOTS); City of Cleveland; Cuyahoga County

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University Hospitals Cleveland Medical Center • Office of Community Impact, Equity, Diversity and Inclusion (CEDI)

CHNA Priority: Accessible and Affordable Health Care

Strategy: Create opportunities to expose minoritized youth to careers in health care:

- UH Health Scholars
- Black Men in White Coats

Goal: Increase the number of minoritized students to engage in various healthcare fields to create pathways for a more diverse and inclusive healthcare workforce.

Participants become healthcare professionals in the Cleveland area, where they grew up to increase access to health care through culturally competent providers.

Objectives:

- Equip 45 students with the necessary post-secondary education/training to prepare them for careers in the healthcare field through the Health Scholars program
- Increase awareness regarding pathways to careers in health care
- Continue to sponsor Black Men in White Coats event in Cleveland, OH

Action Steps:

- Health Scholars: Offer workshops, hands-on activities, shadowing, etc. throughout the year to build and develop social/emotional learning and build on the students' existing talents, skills, and gifts
- Continue to sponsor Black Men in White Coats event by expanding reach and community partners (Track participants)

***Anticipated Measurable Outcome(s) based on current trends:**

- 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
- At least 45 students will complete the Health Scholars program annually (across multiple cohorts)
- Students will enroll in an accredited pre-professional four-year degree program that prepares students for medical school

Indicator(s) used to measure outcomes:

- Health Scholars self-assessments
- Completion of Health Scholars program
- School grades, attendance, disciplinary records, and standardized test scores
- Acceptance into an accredited pre-professional four-year degree program which prepares students for medical school

Collaboration and Partnerships: Cleveland Metropolitan School District, College Now, New Bridge, Case Western Reserve University, Cleveland Clinic, MetroHealth

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Strategies

University Hospitals Parma Medical Center
CHNA Priority: Community Conditions – Access to Healthy Food
Strategy: Nutrition programming to address food insecurity among older adults and children.
Goal: Reduce food insecurities for under-resourced older adults and children in the Parma, Parma Hts, and Seven Hills areas.
Objectives: By December 2025 To increase number of healthy meals delivered to senior citizens in partnership with Meals on Wheels and increase the number of lunches provided to children visiting UH Parma Medical Center in partnership with the Summer Lunch Program.
Action Steps: **Years 1-3:** • Provide at least 800 meals annually to residents of Parma, Parma Hts., and Seven Hills with Meals on Wheels, in collaboration with senior centers in those communities. (Track number of meals provided.) • Provide at least 50 meals to children visiting the hospital annually from June through August through the Youth Summer Lunch Program in partnership with Sodexo, a food management company. (Track number of meals provided.) • Distribute materials at events in Parma, Parma Hts, and Seven Hills to educate community on both Meals on Wheels and Summer Lunch Programs to increase numbers served • Distribute materials at all events to bring awareness of nearby food pantries in the community
***Anticipated Measurable Outcome(s) based on current trends:** • Reduce or maintain the percentage of Cuyahoga County population that experienced food insecurity at some point during the year. (Baseline at 15% – 2020) Healthy NEO website - http://www.healthyneo.org • Maintain the downward trend of people in Cuyahoga County living below the poverty level (baseline: 17.1% 2016-2020) Healthy NEO website – http://www.healthyneo.org
Indicator(s) used to measure outcomes: • Percentage of people in Cuyahoga County living below poverty level. (American Community Survey on the Healthy NEO website: http://www.healthyneo.org) • Food Insecure rate: percent of Cuyahoga County population that has experienced food insecurity at some point during the year. (Feed America on the Healthy NEO website: http://www.healthyneo.org)
Collaboration and Partnerships: Sodexo, Cities of Parma, Parma Heights, and Seven Hills, UH Rainbow Babies & Children Hospital, local food pantries, Parma City School District, Parma Senior Center, Seven Hills Recreation Center & Senior Center, Parma Heights Senior Center

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University Hospitals Parma Medical Center

CHNA Priority: Community Conditions – Community Safety

Strategy: Community-based education and awareness on safety.

Goal: Educate communities on varies safety issues that impact their well-being.

Objectives:

- To increase awareness of safety for older adults, particularly fall prevention and when to call 911. Partnering with UH EMS institute and the Cuyahoga County Parma-Powers Library branch.
- Increase awareness of Child Car Seat Safety checks at the North Royalton Fire Station and other outreach events.

Action Steps:

Years 1-3:

- Provide or participate in events, presentations and/or screenings to the senior community on safety issues that will impact their well-being. Collaborating with area senior centers, City of Parma Safety Day and the Cuyahoga County Parma-Powers Library (Year 1), and UH EMS Training & Disaster Preparedness Institute. (Track number attending event.)
- Continue to provide car seat safety checks at the North Royalton Fire Station. (Track number of car seats checked and/or installed.)
- Distribute materials at events to educate the public on safety issues. (List events and number attended.)
- Distribute materials at events to bring awareness of the child car seat safety checks. (List events and number attended).

***Anticipated Measurable Outcome(s) based on current trends:**

- Reduce or maintain the percentage of death rate for adults due to unintentional injuries. (Baseline: per 100,000 - 67.5% - 2018- 2020) Healthy NEO website - http://www.healthyneo.org
- Reduce or maintain the percentage of death rate in adults due to falls. (Baseline: per 100,000 – 11.5% – 2018-2020) Healthy NEO website - http://www.healthyneo.org
- Reduce the use of wrong car seats or booster seats. Make sure seats are installed correctly. Car seat use reduces the risk of death to infants younger than age 1 by 71% and to toddlers 1 to 4-years-old by 54% in passenger vehicles. Booster seat use reduces the risk of serious injury by 45% for children 4 to 8 years old when compared with seat belt use alone. https://odh.ohio.gov/know-ourprograms/child-injury-prevention/child-passenger-safety/child-passenger-safety

Indicator(s) used to measure outcomes:

- Health/Prevention & Safety – Age-adjusted death rate due to falls in the Healthy NEO website: http://www.healthyneo.org.
- Health/Prevention & Safety – Age-adjusted death rate due to unintentional injuries. Healthy NEO website: http://www.healthyneo.org
- Child Injury Prevention/Child Passenger Safety Ohio Department of Health https://odh.ohio.gov/know-our-programs/child-injury-Prevention/child-passenger-safety/childpassenger-safety

University Hospitals Parma Medical Center
CHNA Priority: Community Conditions – Community Safety
Collaboration and Partnerships: Cities of Parma and North Royalton. Senior Centers located in Parma, Parma Hts., Seven Hills, Independence, Brooklyn, Broadview Heights, North Royalton, Cuyahoga County Parma-Powers Library Branch, UH Rainbow Babies & Children Hospital, UH EMS Training & Disaster Preparedness Institute

*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 Center
CHNA Priority: Accessible and Affordable Health Care
Strategy: Increase access to community-based education and health screenings to prevent and/or manage chronic diseases, particularly for diabetes and coronary heart disease.
Goal: Improve the well-being of adults in Cuyahoga County to create access to disease prevention and management, reduce incidence of diabetes, and coronary heart disease.
Objectives: • Detect early signs of chronic diseases by offering screenings in an effort to prevent or mitigate disease progression (target: 1,500 screens annually). • Increase awareness through education of chronic disease prevention and management to improve health literacy and health outcomes.
Action Steps: **Years 1-3:** • Offer and participate in community-based events, offering free screenings and health-related materials, emphasis on addressing diabetes and coronary heart disease. (Track number of participants screened, positive screening results and ZIP codes.) • Provide nutritional and healthy lifestyle information and speakers to our community at large including area senior centers, support groups and other community partners and our Cardiac Rehab Program. (Track number of attendees.) • Provide educational materials to in-patients with an A1C greater than 5.7 (pre-diabetic) upon discharge. (Track number of encounters.) • Provide a handout at screening events that provides information about financial aid to those with little or no insurance. (Track the number of events.)
***Anticipated Measurable Outcome(s) based on current trends:** • Reduce or maintain the age-adjusted death rate due to diabetes in Cuyahoga County (baseline: 23.2 per 100,000 population from 2018-2020). • Reduce or maintain the age-adjusted death rate due to coronary heart disease in Cuyahoga County (baseline: 105.7 per 100,000 population from 2018-2020)
Indicator(s) used to measure outcomes: • Age-adjusted death rate due to diabetes. (Centers for Disease Control on the Healthy NEO website: http://www.healthyneo.org/) • Age-adjusted death rate due to coronary heart disease. (Centers for Disease Control on the Healthy NEO website: http://www.healthyneo.org/)
Collaboration and Partnerships: Senior centers in UH Parma Medical Center service areas, community health fairs, North Royalton City Schools, Parma City School District, Padua High School, St. Albert the Great School, Brecksville-Broadview Heights City School District, North Royalton YMCA, Parma Branch – Cuyahoga County Public Library, cities of Parma, North Royalton, Parma Heights, Seven Hills, Brooklyn, Independence, 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.

Strategies

University Hospitals Rainbow Babies & Children's
CHNA Priority: Community Conditions
Strategy: Rainbow Connects – social needs screening and navigation.
Goal: Reduce the percentage of patients who report they cannot access enough healthy food for themselves or their children and provide additional social support as needed.
Objectives: • Screen at-risk patients for food insecurity and other essential social needs (baby supplies, utilities, eviction prevention etc.). • Provide high quality resource navigation to link patients to essential community services to address their social needs.
Action Steps: **Year 1:** The Rainbow Connects program, housed at the UH Ahuja Rainbow Center for Women & Children, will screen all pediatric patients for food insecurity and other social needs. A team of student volunteers (~30) and two full-time community health workers will provide both on-site and telephonic outreach to patients, linking them to community resources, UH-led initiatives (Food for Life Market) and offer tangible supports, as needed (emergency food bags, diapers, clothes). **Year 2:** Develop procedures and codify the training and onboarding of Rainbow Connects volunteers and staff in order to lay the groundwork to expand the Rainbow Connect model to other services across Rainbow Babies Children's and MacDonald Women's Hospital, including the NICU, Labor & Delivery and Pediatric Dentistry **Year 3:** Pilot the expansion of the Rainbow Connects model in at least 2 new service areas. Collaborate closely with staff to identify processes and procedures to offer screening and navigation services. Formalize the creation of a system-wide Rainbow Connects resource repository that houses all key community partnerships and is updated and maintained regularly.
***Anticipated Measurable Outcome(s) based on current trends:** • Increase the percentage of food-insecure patients who are connected to emergency food and essential community resources like the Food Bank and the Hunger Network • Increase the percentage of patients who are connected to other social resources to assist with utility and rental assistance, and clothes, diapers and car seats • Increase the number of patients screened across Rainbow & MacDonald Women's services by 30 percent over 3 years
Indicator(s) used to measure outcomes: • Rainbow Connects screening form & data collected through Redcap Rainbow Connects registry UH Care Ambulatory/EPIC • Center for Child Health & Policy annual LINK Survey
Collaboration and Partnerships: The Greater Cleveland Food Bank, The Hunger Network, UH Food 4 Life Program, CHN Housing Partners, Legal Aid Society

*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
CHNA Priority: Accessible and Affordable Health Care/Behavioral Health
Strategy: Centering Pregnancy.
Goal: To improve health outcomes for at-risk pregnant women and infants by decreasing preterm birth and low birth weight, reducing mental and social stress, and increasing healthy behaviors (breastfeeding, safe sleep, and smoking cessation).
Objectives: • To identify at-risk pregnant women and their families and enroll them in Centering Pregnancy and Centering Parenting programs. Address their social, environmental, and mental health needs while providing prenatal and infant pediatric care. • Decrease the number of infant deaths • Decrease racial disparities • Decrease preterm deliveries and low birth weight infants • Increase breastfeeding
Action Steps: **Year 1:** The Centering Pregnancy and Centering Parenting Program, housed at the UH Ahuja Rainbow Center for Women & Children, are unique care models that enable midwives and pediatricians to provide women with pregnancy and birth-related information, and new parents with infant care information in a group setting. These program offer health assessments, education, connection to social needs services, and mental health support, all in a supportive environment. **Year 2:** Expand access to social needs services, education and mental health supports for women and young families who opt for traditional (non-Centering) care at the UH Rainbow Ahuja Center in order to mirror the positive outcomes of those enrolled in group care **Year 3:** Provide intentional and targeted mental health support to pregnant moms and families with infants to help destigmatize mental health/stress, provide on-site "bridge" counseling and coordinate services with outside mental health providers.
***Anticipated Measurable Outcome(s) based on current trends:** • Enroll 250 pregnant moms and 100 families with infants into Centering Pregnancy and Centering Parenting annually. • Enroll 100 non-group care pregnant women and 100 families with infants into expanded social support service. • Continue decrease in the infant mortality rate in Cuyahoga County (baseline: 7.7 per 1,000 live births in 2020). • Decrease preterm births (less than 37 weeks gestation) in Cuyahoga County (baseline: 11.6% in 2021)

University Hospitals Rainbow Babies & Children's
CHNA Priority: Accessible and Affordable Health Care/Behavioral Health
Indicator(s) used to measure outcomes: • Centering Pregnancy Redcap registry • UH Care Ambulatory/EPIC • Center for Child Health & Policy annual LINK Survey • 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/)
Collaboration and Partnerships: First Year Cleveland, Birthing Beautiful Communities, Towards Employment, CHN Housing Partners

*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
CHNA Priority: Community Conditions/Behavioral Health
Strategy: Antifragility Initiative- a holistic, person-centered pediatric Hospital-based Violence Intervention Program (HVIP) serving youths and families in the greater Cleveland area.
Goal: Reduce re-injury rate for children ages 6 to 15 who live in Cuyahoga County and are treated at UH Rainbow Babies & Children's Hospital for non-accidental injuries related to peer or community violence.
Objectives: Identify eligible patients, provide rapid outreach, assess needs, create goals, and execute appropriate interventions. Identify relevant Social Determinants of Health (SDOH) and target interventions. Support developmental progression through positive, educational, and prosocial activities.
Action Steps: **Year 1:** Implement standardized screening and intervention for PTSD symptoms among pediatric trauma patients in compliance with the American College of Surgeons mandate for Level 1 Pediatric Trauma Center designation. Update Antifragility (AI) policies and procedures manual to align with the HAVI standards and indicators model. Recruit, train, and retain staff to better meet AI goals and objectives. **Year 2:** Conduct outcomes and other research for quality improvement, determine population needs, and provide targeted interventions. Seek to expand community partnerships and find ways to increase access to positive, educational, and pro-social activities (art, theater, music, sports, vocational, summer programming, and more). Put additional resources into more training in evidence-based interventions, such as EMDR therapy, and materials/equipment to improve clinical outcomes. **Year 3:** Investigate expansion of service model to include outside referrals from UH outpatient pediatric offices and specialized high-risk populations such as incarcerated youth. Develop protocols and procedures, and provide training towards expansion. Establish a "survivor network" to provide opportunities for survivors of peer and community violence to connect through community events, volunteer opportunities, support groups, and a newsletter. Offer trainings on Social Determinants of Health, Adverse Childhood Experiences, and Trauma Informed Care.
***Anticipated Measurable Outcome(s) based on current trends:** • Overall reduction in the re-injury rate among children, youth, and teens meeting AI criteria. • Increased access to high quality, evidenced-based, and trauma informed mental health interventions for those meeting AI criteria. • Decrease in food insecurity among patients meeting criteria for AI • Standardized screening and intervention for Social Determinants of Health (SDOH) including healthcare access, education, safety, housing, clothing, food insecurity, and more • Improved rate of engagement among eligible AI participants versus enrolled AI participants

University Hospitals Rainbow Babies & Children's
CHNA Priority: Community Conditions/Behavioral Health
Indicator(s) used to measure outcomes: • UH/Rainbow hospital records • STEPP tool • The Hunger Vital Sign • Antifragility Initiative clinical and enrollment records
Collaboration and Partnerships: The Ohio Attorney General's Office, The HAVI, The Greater Cleveland Foodbank, The Rainey Institute, The Cleveland Peacemakers Alliance, the City of Cleveland, Project Lift, and Shoes & Clothes for Kids

*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
A CATHOLIC HOSPITAL

University Hospitals St. John Medical Center
CHNA Priority: Accessible and Affordable Health Care
Strategy: Community-based education and health screenings to prevent and/or manage chronic diseases, particularly for diabetes, and coronary heart disease.
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: • Promote healthy lifestyle choices to at least 1000 individuals annually through exercise programs, Health talks and nutrition education • Detect early signs of chronic diseases by offering screenings in an effort to prevent or mitigate disease progression (target: 1,500 screens annually, at least 100 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:** • Offer and participate in community-based events, offering free screenings and health-related materials, emphasis on addressing diabetes and coronary heart disease. (Track number of participants screened and positive screening results.) • Provide nutritional and healthy lifestyle speakers to area senior centers and other community partners. (Track number of participants and relevant outcomes.) • Identify and initiate strategic partnerships with three new local organizations annually (include notes on progress in Comments). • 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. (Include notes on progress in Comments.) • Increase awareness and education on stroke prevention and overall wellness through new stroke program and screenings (educate and screen 500 people annually).
***Anticipated Measurable Outcome(s) based on current trends:** • Reduce or maintain the age-adjusted death rate due to diabetes in Cuyahoga County (baseline: 23.2 per 100,000 population from 2018-2020). • Reduce or maintain the age-adjusted death rate due to coronary heart disease in Cuyahoga County (baseline: 105.7 per 100,000 population from 2018-2020).

University Hospitals St. John Medical Center
CHNA Priority: Accessible and Affordable Health Care
Indicator(s) used to measure outcomes: • Age-adjusted death rate due to diabetes. (Centers for Disease Control on the Healthy NEO website: http://www.healthyneo.org/) • Age-adjusted death rate due to coronary heart disease. (Centers for Disease Control on the Healthy NEO website: http://www.healthyneo.org/)
Collaboration and Partnerships: LCADA Way, Seidman Cancer Center, Westside Health Organization, senior centers in UH St. John Medical Center service areas, CommUNITY health talks, fairs and events, Westlake, North Olmsted and Bay Village City School Districts, Westlake Public Library, cities of Westlake, North Olmsted, Rocky River, Fairview, Lakewood and Bay Village, Crocker Park, American Greetings, Equity Trust, Fedor Manor, Westlake YMCA, local churches, Goodwill Industries, Westlake Service Center, Westlake Recreation Department, local fire stations

*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: Behavioral Health (Mental Health and Addiction)

Strategy: Community-based education, health screenings and community collaborations to address mental health and addiction.

Goal: Educate the community on dangers of substance use/misuse, strategies to improve mental health and resources offered in their community.

Objectives:

- Increase knowledge about the risks and resources available to prevent or treat substance addiction.
- Increase awareness and education of alternative methods to address mental health and addiction (target: 1,000 annually).

Action Steps:

Years 1-3:

- Offer and participate in community-based events, develop community based approaches to increase outreach and understanding of behavioral health issues and resources. (Track number of individuals reached.)
- Partner with LCADA (Lorain County Alcohol and Drug Addiction services) and other community agencies to promote and raise awareness of programs and services within the community.
- 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.
- Provide health education and hands-on activities to local schools.

***Anticipated Measurable Outcome(s) based on current trends:**

- Reduce or maintain the percentage of Lorain County population stated that their mental health, which includes stress, depression, and problems with emotions, was not good for 14 or more of the past 30 days. (Baseline at 16.5% – 2019) Healthy NEO website – http://www.healthyneo.org

Indicator(s) used to measure outcomes:

- The average number of days that adults reported their mental health was not good in the past 30 days. Healthy NEO website - http://www.healthyneo.org
- The percentage of households with at least one person who received mental healthcare medical services in the past 3 years in Lorain County was 7.1%. http://www.healthyneo.org

Collaboration and Partnerships: LCADA Way, Seidman Cancer Center, Westside Health Organization, senior centers in UH St. John Medical Center service areas, CommUNITY health talks, fairs and events, Westlake, North Olmsted and Bay Village City School Districts, Westlake Public Library, cities of Westlake, North Olmsted, Rocky River, Fairview, Lakewood and Bay Village, Crocker Park, American Greetings, Equity Trust, Fedor Manor, Westlake YMCA, local churches, Goodwill Industries, Westlake Service Center, Westlake Recreation Department, local fire stations

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

Other UH Community Health Initiatives

University Hospitals has invested $3.5 billion over the last decade toward critical needs in the community. As an anchor institution, UH is in a unique position to influence population health and advance economic opportunities for communities it serves. UH is proactively looking to contribute to the health of residents in Cuyahoga County and beyond by directly addressing social determinants of health. There are various other initiatives UH has deployed in addition to the strategies developed in direct response to the CHNA. A few of the initiatives are listed below:

Anchor & Social Venture Investment

Economic Stability is a SDOH which is why University Hospitals is invested in fostering economic growth to aid in improving the health of Northeast Ohio residents. UH has been guided by a strong commitment to civic and social responsibility, leveraging its role as an anchor institution to build physical and economic health for the community. Examples of this include involvement in "hire local, live local and buy local" efforts such as Step Up to UH, a jobs pipeline program; Greater Circle Living, an employee-assisted housing program; Evergreen Cooperatives, which creates local green jobs; and New Bridge Cleveland, which provides career training for adults and after school classes for urban high school students.

Lead Safe Cleveland & First Year Cleveland (FYC)

UH remains actively engaged in regional initiatives to address lead safety and infant mortality. Lead poisoning has put thousands of Cleveland area children on a path of cognitive decline and poor school performance. Preventing lead poisoning reduces those problems and can save children in Cleveland's neighborhoods. As part of its Community Health Investment Strategy to improve community conditions and population health, University Hospitals committed $1.2 million to the Lead Safe Cleveland Coalition, the public/private partnership that was formed to address and prevent the pernicious issue of lead poisoning.

First Year Cleveland was established in 2015 to address the high infant mortality rates in Cuyahoga County. First Year Cleveland (FYC) is a community movement dedicated to reversing this trend and helping all babies celebrate their first birthdays. UH has remained active in collaborating with FYC and held leadership roles within the organization to help to advance the goal of reducing infant mortality and the racial disparities that are disproportionately impacting black babies in Cuyahoga County.

UH Health Clinics

University Hospitals has a number of health centers anchored in communities that have long suffered from health inequities and adverse conditions. The scope of care is beyond clinical, addressing social determinants of health and providing wrap-around services for patients and families. The programs and services offered directly align with UH's enhanced Community Health Investment Strategy but also address many of the priority needs identified in the CHNA.

UH Rainbow Babies & Children's Ahuja Center for Women & Children

The UH Rainbow Babies & Children's Ahuja Center for Women & Children opened in the summer of 2018 as an opportunity to make health more accessible to patients. And it has become a special place for families to address not only their health, but their wellness and social needs. The 40,000-square foot, three story center is located in the heart of Cleveland's Midtown neighborhood and is helping to improve access to quality care for the residents of Cleveland and surrounding communities by providing both traditional medicine and community services tailored to the needs of the neighborhood. This space was created for the community by the community. To design the center , in 2016, UH Rainbow Babies & Children's created a Community Advisory Board made up of about 60 members of the community, including those who live in the neighborhood as well as individuals working in public health, LBGT health, education, employment and food distribution.

The UH Rainbow Ahuja Center features pediatric primary care, women's health and OB/GYN services. In addition mental and behavioral health services, nutrition education, a full-service vision clinic operated by the nonprofit ONeSight, pediatric dental services, legal services and a WIC office and pharmacy all housed in one convenient facility. Through this model of care, UH hopes to lower neighborhood infant mortality rates, diabetes and preterm births, among other things.

UH Glenville Services at the Davis

UH Glenville Community Health Services will be located at the Davis, a new affordable housing complex in Cleveland's Glenville neighborhood. The 2,500-square foot UH-managed Community Wellness Center will be located on the ground floor of the housing complex and open to the community. This partnership is a collaboration among NRP Group, University Hospitals, the City of Cleveland, the Cuyahoga Metropolitan School District and the Cleveland Metropolitan School District. The innovative co-location of UH programs within a housing complex will address the need for access to care, health education and healthy food. UH will directly connect local residents to focus on wellness, health education, offer access to virtual physician visits and will feature a Food for Life Market and full cooking demonstration. This is an opportunity to improve population health by reducing disparities in the care and chronic health conditions. The UH Glenville Community Health Services at the Davis is expected to open in July 2023.

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

Since 1997, the UH Otis Moss, Jr Health Center has been serving the Fairfax community since 1997. The UH Otis Moss Health Center was established in close partnership with the Olivet Institutional Baptist Church. The center provides high-quality patient care in a spiritually supportive environment. The health center provides patients with a broad range of health care services including Family Medicine, Men's Health and Urology Services and Mental Health/Psychiatry Services. In October 2018, the health center opened a Food for Life Market to set patients up for success in nutrition and dietary education. The Market is part of a holistic approach to addressing food insecurity and the medical conditions, including chronic health conditions, that are impacted by nutrition and access to healthy food in rural areas and food deserts. Also offered are consultations with a registered dietitian. UH partners with Olivet Institutional Baptist Church, the Olivet Housing and Community Development Corporation, New Bridge workforce training program, and Cuyahoga Community College to provide workforce development and employment opportunities.

Richmond and Bedford Community Wellbeing Programs

University is currently working on the implementation of Community Well Being programs in the cities of Bedford and Richmond located in Cuyahoga County. The community health investment strategy promotes health equity and wellness for residents of the cities of Bedford and Richmond and surrounding communities. UH plans to start new wellness programs and services focusing on wellness and safety, maternal and child health, food security, and workforce development. The emphasis will be on early detection to treat people before they get sick. The goal is provide a place for the community that not only addresses their health, but their wellness and social needs that impact their overall health.

UH Cutler Center for Men's Health

University Hospitals Cutler Center for Men provides men with unprecedented and uncomplicated access to the health experts, services and resources needed for a lifetime of good physical, mental and emotional health. The UH Cutler Center for Men program helps men get to the experts and resources they need for a lifetime of physical, lifestyle and emotional health. The Cutler Center is located at the UH Ahuja Medical Center in Beachwood and at the UH Otis Moss Health Center in the Fairfax neighborhood. The Cutler Center brings together primary care doctors and specialists in heart disease, urology, digestive health, mental health, orthopedics, among other specialties. The UH Cutler Center offers health navigators known as the Joe Team to help men manage their care and address barriers to care including the social determinants of health. The Cutler Center is working to address the large number of men not engaged with health and to redefine what men's health care looks like. With 250,000 less men than women seeing a doctor per year in Cleveland alone, the Cutler Center is working to address this staggering statistic and improve health outcomes for men in Northeast Ohio.

Cuyahoga Collaborative Strategies (County-Aligned Strategies)

In addition to the specific hospital strategies listed in this report, several emerging initiatives are underway that will allow regional stakeholders to work collaboratively on shared "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 identified priorities. UH will not serve as the leader in these strategies but will participate by designating appropriate staff to engage in work groups involved in these collaborative efforts. Cuyahoga county aligned strategies include:

- Aligned Health Priority: Community Conditions Access to Healthy Foods

  Goal: Ensure that everyone has access to healthy foods
- Aligned Health Priority: Community Conditions Community Safety

  Goal: Modify the physical and social environment to reduce exposure to community level risk
- Aligned Health Priority: Accessible and Affordable Health Care

  Goal: Increase equitable access and affordable healthcare services
- Aligned Health Priority: Behavioral health (Mental health and Drug Use/Misuse)

  Goal: Mental/behavioral health is accessible and integrated with primary care

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. This is not the end but rather the beginning of the process to cultivate the aligned strategies. To refine this collaborative effort, work groups are being formed around each aligned health priority to further define strategies, outcomes and the process for implementation.

Significant Health Needs Not Being Addressed by the Hospital

UH Hospitals are implementing strategies along with the Cuyahoga Community Health Partners for all of the priorities identified in the 2022 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. Although UH medical centers are collectively addressing all three priorities, there are several community health needs 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.

- School-based programs and implementing farm to school plan
- Violence prevention efforts

Qualifications of Consulting Company

The process to develop this IS was facilitated by Conduent Health Communities Institute (HCI). HCI works with clients across the nation to improve community health by assessing needs, developing focused strategies, identifying appropriate intervention programs, establishing monitoring systems, and implementing performance evaluation processes. To learn more about Conduent Healthy Communities Institute, please visit https://www.conduent.com/communityhealth/.

The Center for Health Affairs was also instrumental in the development of the 2023-2025 Implementation Strategies for the Cuyahoga community health partners. The Center for Health Affairs has served as the collective voice of Northeast Ohio hospitals for over 100 years. The Center's community health program empowers member hospitals to meet their community health goals and achieve equitable and improved health outcomes for all. Supporting hospitals in their community health work is central to The Center's community health program. They seek to help member hospitals build strong partnerships and align their efforts with one another, public health departments, community stakeholders and community residents. More information about The Center for Health Affairs and its involvement in CHNAs can be found at www.chanet.org.

Contact Information

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Appendix A

2023-2025 Cuyahoga County Community Health Improvement Plan Strategies

Aligned Health Priority: Community Conditions Access to Healthy Foods			
Goal: Ensure that everyone has access to healthy and nutritious foods			
Aligned Strategies			
★ Increase access to nutritious foods by connecting the local food system to serve Early care and education (ECE) and K-12 school systems			
Improve health by the continued promotion of healthy eating and increase making nutritious foods	Policy effort to lower thresholds and higher amounts for WIC and SNAP	Full scale grocery stores (accessible to all)	Address transportation needs to improve food access
Access to healthy food including a built out of purchasing power over locally grown food	Expanding organizational capacity to support regional local food system efforts, partnership and planning	Increase local food purchasing by K-12 school systems and ECE programs	Strengthen the mid-tier value chain to effectively serve K-12 schools and ECE programs

Planned Collaboration:

The previous community health improvement plan from 2015 focused on healthy eating and active living, and that work has now shifted to be primarily focused on access to healthy foods as an aligned health need. The current and future efforts in this strategy will be anchored by the work of the Cuyahoga County Board of Health and its community partners. The work involves implementing a regional farm to school and farm to early care and education program aimed at improving nutrition security for school-aged children, expanding reach to 45 counties in Ohio, and addressing food system equity. This work plan will continue to be developed over the next few months with the goal of improving access to healthcare services, and the strategy will be implemented over the three-year cycle. The work plan will focus on short-term and long-term outcomes and will be evaluated over time to ensure it meets the community's needs.

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

*PLEASE NOTE THE CHIP/IS IS A LIVING DOCUMENT ADAPTED IN RESPONSE TO EVERCHANGING CITIZENS, COMMUNITY AND STAKEHOLDER NEEDS. ANY LIST(S) OF PARTNERS INCLUDED IS NOT EXHAUSTIVE. THE COLLABORATIVE WELCOMES ANY ORGANIZATIONS AND STAKEHOLDERS INVOLVED IN PRIORITY-CENTERED WORK TO JOIN OUR EFFORTS.

★ INDICATES THE TOP ALIGNED STRATEGY PER THE COLLABORATIVE RANKING ACTIVITY

Aligned Health Priority: Community Conditions Community Safety		
Goal: Modify the physical and social environment to reduce exposure to community level risk		
Aligned Strategies		
Youth mentor and gun violence prevention approaches	★ Invest in economic and educational opportunity in neighborhood with high violence (i.e., Crime Prevention Through Environmental Design- CPTED)	Intervene to lessen harms and prevent future risk

Planned Collaboration:

Community Safety as an aligned health priority centers on reducing exposure to various environmental risks, specifically, violence in the community. The top ranked strategy is investing in equity, economic, and educational opportunities at neighborhood levels where violence is concentrated. The collaborative recognizes there is a challenge in identifying the organizations and individuals who are ready to lead these efforts to align programmatic work as a community. The first planned collaboration is to conduct an environmental scan to understand who is doing what work and what data exists on penetrating trauma and gun violence. There is a possibility of implementing a 10-year violence prevention strategic plan in 2023 with the aim of making identified neighborhoods safer. The development of a violence prevention committee is underway with community partners. This work plan will continue to be developed over the next few months with the goal of improving access to healthcare services, and the strategy will be implemented over the three-year cycle. The work plan will focus on short-term and long-term outcomes and will be evaluated over time to ensure it meets the community's needs.

Aligned Partners:

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

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★ INDICATES THE TOP ALIGNED STRATEGY PER THE COLLABORATIVE RANKING ACTIVITY

Aligned Health Priority: Accessible and Affordable Healthcare		
Goal: Increase equitable access and affordable health care services (including specialists)		
Objective: From 2023 to 2025, the Collaborative aims to improve equitable access through standardizing the integration of tools that facilitate inter- and intra-agency referrals.		
Aligned Strategies		
Improve community-based preventive care	★ Integrated health and social care to serve the whole person at the right place, at the right time by the right people with the right resources	Cultural sensitivity training for health care providers; immersing health care providers in under-resourced communities
Increase system investment in primary care and safety net specialty care to support a person and relationship- focus for health care	Enhance the value of community-based primary care team approach to avoid inappropriate use of ER, readmission and institutional care (hospital, nursing home, etc.) with focus on preventive approach, care management and home health care	Standardize Social Determinants of Health assessment and implement appropriate timely and adequate intervention

Planned Collaboration:

The Collaborative continues discussion about creating a strategy for accessible and affordable healthcare services. The focus is on increasing equitable access to healthcare, with a specific emphasis on behavioral health and alignment with that prioritized health need. There is an emphasis on the importance of integrated health and social services and acknowledgement that there is room for improvement in terms of accessibility of clinical services. The input of the community health worker network will be interwoven, as well as access for newcomers to the community (immigrants and refugees). This work plan will continue to be developed over the next few months with the goal of improving access to healthcare services, and the strategy will be implemented over the three-year cycle. The work plan will focus on short-term and long-term outcomes and will be evaluated over time to ensure it meets the community's needs.

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Aligned Health Priority: Behavioral health (Mental health and Drug Use/Misuse)		
Goal: Mental/behavioral health is accessible and integrated with primary care		
Aligned Strategies		
Alcohol and other drug use screening	★ Coordinated care for behavioral health	Suicide awareness, prevention and peer norm programs
Comparable insurance coverage for mental health	Improve mental health and decrease substance misuse	Housing programs for people with behavioral health conditions
Increase access to harm reduction (naloxone, fentanyl test strips, safe use supplies, etc.)	Identify disparate populations and create linkages to care for at-risk populations	Mental/behavioral health accessible and integrated with primary care (Accessible Substance Use Disorder treatment)

Planned Collaboration:

The behavioral health aligned health priority focuses on drug abuse, access to mental health care, and the opioid crisis. It is closely related to the access to health care health priority and has specific pieces focused on these issues. At the neighborhood level, cocaine and methamphetamine use were also identified as concerns. This priority aligns with the Neighborhood CHNA and the focus on mental health for adults and children. This work plan will continue to be developed over the next few months with the goal of improving access to healthcare services, and the strategy will be implemented over the three-year cycle. The work plan will focus on short-term and long-term outcomes and will be evaluated over time to ensure it meets the community's needs.

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